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THESIS

A CONTEST WITHOUT A LOSER:
THE DEVELOPMENT OF THE NAVY's
ALCOHOL REHABILITATION PROGRAM.

Lynford S. Walters, III

June 1981

Thesis Advisor: R. A. McGonigal

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The purpose of this thesis is to describe the development and integration of the Alcohol Rehabilitation Program from 1965 to 1980. It shows that throughout this period Naval organizational needs and Alcohol Program needs were being met. It also illustrated that the Navy and Alcohol Program personnel acted in accordance with their own goals and vested interests, both to their mutual benefits. These two different goals were brought

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A Contest Without a Loser:
The Development of the Navy's
Alcohol Rehabilitation Program

by

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Lieutenant Commander, United States Navy
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Submitted in partial fulfillment of the
requirements for the degree of

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I. INTRODUCTION

A. PURPOSE

The purpose of this thesis is to describe the development and integration of the Alcohol Rehabilitation Program from 1965 to 1980. It shows that throughout this period, Naval organizational needs and Alcohol Program needs were being met. Both the Navy and Alcohol Program personnel acted in accordance with their own goals and vested interests.

Specifically, from the Navy's side, the problems facing the organization were the inevitable post war reduction in manpower when peace came to Vietnam and the legislation about to be enacted requiring the end of conscription. This would mean the Navy would have to draw it's future manpower from increased re-enlistment rates of qualified active duty personnel, and/or from the society at large. In either case it meant increased social action programs by the Navy to align itself with society's current values.

From the Alcohol Rehabilitation Program supporters viewpoint, most of the leaders and workers in the office were recovered alcoholics who had conquered their disease through Alcoholics Anonymous (AA). The perceived responsibility for an attendee of AA was to help other alcoholics help themselves. These recovered alcoholics were modern day crusaders out to "save the lives" of those who were currently alcohol

abusers or alcoholics. These supporters understood the disease and felt with the proper resources they could establish a network of programs in the Navy to reach this goal.

The forces that brought these two goals together occurred at approximately 1970. These forces were the Vietnam War, selection of Admiral Elmo R. Zumwalt as Chief of Naval operations and passage of Public Laws 91-616 and 92-129 on Alcohol Abuse. The leaders of the Alcohol Program utilized these forces well, and through proper management of their Program, it became an established support unit of the Navy.

This thesis is organized into seven chapters. Chapters II through VI illustrate major stages of development and integration of the Alcohol Program. The final chapter addresses conclusions from the data.

B. METHODOLOGY

Due to the broad scope of this study and the dearth of available literature on the historical development of alcohol rehabilitation in the Navy, the major historical perspectives were gained through interviews of both incumbent and non-incumbent personnel in the Navy Alcohol Program. Virtually all of the early major leaders in the Program were interviewed in addition to many officials currently in place. A total of 19 interviews were done, 11 by phone and 8 in person. Those done in person included 1 at Long Beach Naval Hospital, 5

at ARC San Diego and 2 in Washington D.C. All interviews were done within a three month period from January to March 1981. Each lasted from 30 minutes to 3 hours.

The second methodology utilized was literary data. Additional data were gathered from instructions, notices, newsletters, messages, original letters/point papers, transcripts, and magazines. Instructions and notices included all available issued on Drug and Alcohol Programs by SECNAV, OPNAV, BUPERS, and most recently CNMPC. Newsletters from Alcohol Prevention Program and the National Council on Alcoholism were reviewed. Messages including Z-grams (Admiral Zumwalt CNO messages) and applicable OPNAV and BUPERS messages were examined. In addition, original letters/point papers were acquired through historical files in the Drug and Alcohol Office in Washington D.C. and material was sent to me by many of the early members of the program. It included commendations to early Alcohol Program leaders' notes addressing Program name changes, in-house memorandums on Program status, and unpublished point papers on justification of ARC's, NASAP's and CAAC's addressed to the Chief of Naval Personnel.

A number of Senate Hearings were held concerning alcohol abuse. Two in particular; the Subcommittee on Alcoholism and Narcotics, ninety first Congress held in November and December of 1970, and the discussion by the ninety second Congress on Title V of Public Law 92-129, were considered

significant to the historical development of the Navy's Alcohol Program. Finally, a number of magazine articles were reviewed. Of particular interest were the Time Magazine "Essays." These gave great insight to the public conscience during the war in Vietnam, when the Alcohol Program was just starting.

Secondary data, the last methodology, were acquired through external and internal research projects. Approximately 20 were surveyed including Naval Health Research Reports 78-48, 79-58, and 80-10; Rand R-2308-AF, "Alcohol Problems, Patterns and Prevalence in the U.S. Air Force;" Presearch Inc. Report no. 394, "Summary of Cost Benefit Study Results for Navy Alcoholism Rehabilitation Programs," and "1978 Evaluation of the NASAP and Alcoholism Counselor Training Programs," by NARC, San Diego.

C. TERMS AND DEFINITIONS

The following definitions are recognized by the Chief of Naval Operations in various instructions and are an accumulation of terms used throughout this thesis:

Alcohol-a chemical compound known as CH_3CH_2OH, commonly called ethanol. It is normally found in three major classes of beverages; beer, wine and distilled spirits.

Alcoholism-a nonratable disease characterized by psychological and/or physical dependency on alcohol.

Alcoholic (Alcohol Dependent)-a general reference to an individual who suffers from alcoholism.

Alcohol Abuse-any irresponsible use of an alcoholic beverage which leads to misconduct, unacceptable behavior, or impairment of an individual's performance of duty, physical or mental health, financial responsibility, or personal relationships. It may also lead to alcoholism.

Alcoholics Anonymous-an organization of recovering alcoholics dedicated to the mutual self support of those afflicted with the disease of alcoholism, through the model of 24 principles, including twelve steps to sobriety (Appendix A).

Alcohol Addiction-a physiological condition in which there usually is a marked change in tolerance to alcohol, and consumption of alcohol is necessary for the prevention of withdrawal symptoms.

Alcohol Rehabilitation Center (ARC)-provides inpatient treatment for alcohol dependent personnel. Each has approximately 80 beds for a 6 week program of rehabilitation. Referral is through the Armed Services Medical Regulating Office (ASMRO). All three are under the functional control of Chief of Naval Personnel.

Alcohol Rehabilitation Drydock (ARD)-rehabilitation units sponsored by the Bureau of Naval Personnel, distributed to local commands and functionally under the control of major commands such as Commander in Chief Pacific Fleet. It was an abbreviated treatment for alcohol abusers, allowing the local commands to treat their own less serious cases.

Alcohol Rehabilitation Service (ARS)-provides inpatient treatment for alcohol dependent personnel. Each of the 24 ARS's are located in Navy hospitals and have approximately 15-25 beds each. Referral is primarily through the Armed Services Medical Regulating Office (ASMRO). All 24 are under the functional control of the Chief of Medicine and Surgery.

Counseling and Assistance Center (CAAC)-formally called CARE centers; are currently established in 67 locations. Their major function is to screen and evaluate alcohol and drug abusers, to make disposition recommendations to commanding officers of their assigned locations, and to provide counseling and/or referral for additional treatment as necessary.

Intoxication-a state of impaired mental and/or physical functioning, resulting from the presence of alcohol in a person's body. This condition does not necessarily indicate alcoholism as defined here, nor does the absence of observable intoxication necessarily exclude the possibility of alcoholism.

Navy Alcohol Safety Action Program (NASAP)-a program directed toward the early identification and prevention of alcohol abuse among Naval personnel. It consists of an after working hours course of 36 hours instruction in alcohol abuse and alcoholism for persons involved in alcohol-related military or civilian offenses.

Problem Drinker (Habitual Alcohol Abuser)-a person who may or may not be an alcoholic, but whose use of alcohol conforms to the definition of alcohol abuse.

Recovered Alcoholic-a person whose alcoholism has been arrested. Normally, this is accomplished through abstinence and is maintained through a continuing personal program of recovery (ordinarily sponsored by AA).

II. THE BEGINNING (4000 B.C.-1970)

"Bureaucracy defends the status quo long past the time when quo has lost it's status"

Laurence J. Peter

A. INTRODUCTION

One of the enlightened men of the silver screen stated that it was a woman that drove him to drink and he never stopped to thank her. The man was W. C. Fields and the drink, of course, was alcohol. It has been with us for at least as long as recorded history and even today is used in many ceremonies in which man participates. From house warmings to office parties, from sports events to holy holidays, alcohol is often the focus of celebration. While its use is widely accepted throughout our culture, its abuse is not.

Traditionally, the U.S. Navy has been viewed as being a group of hard living, hard working, hard drinking people. For close to two hundred years alcohol had been part of the Navy's methodology for comradery and perceived as a necessary compensation for the rigors in development of an effective fighting force. Observe a few of the uses:

Formal Dining-ins

Change of Command Ceremonies

Chief's Initiations

Happy Hours

Wetting Downs

Navy Birthday Balls

Liberty Calls

Launching of Ships

For years the cost in both personnel and dollars was acceptable for the Navy and many alcohol abusers could handle a schedule of working and drinking with little adverse effect. Others, however, were not so lucky.

A recent study estimated that one in ten suffers from chronic alcohol abuse and additional studies indicate the Navy at large is no different than the civilian population. It is a multi-billion dollar problem touching both civilian and military personnel. The total loss the Navy is estimated between 360-680 million dollars annually [1]. Countless man-hours are lost because of alcohol related illnesses or hospitalizations and it is now recognized as the number three health problem in the United States, closely following heart disease and cancer [2].

Until recently, little was known about the problem. Like much of the civilian industry, alcoholic sailors were typically hidden and tolerated in the system without resolution of their difficulties with alcohol until they proved to be ineffective. It is only now, after at least 4000 years of use, that we are beginning to understand the alcohol abuser.

B. EARLY HISTORY

The development of programs to assist the abuser really began with Alcoholics Anonymous (AA) in 1935. It eventually demonstrated that a large number of alcoholics could be saved; e.g., continue productivity in society, using a model developed by two recovering alcoholics.

The twelve steps to sobriety (Appendix A), developed the basic principles and heart of the AA recovery process. These principles are still in use today.

By 1944, Mrs. Marty Mann had founded the National Council on Alcoholism, a national voluntary health agency. The agency worked from 1944-1959 attempting to develop alcoholism programs for employees of companies and government departments. By 1959, there were only 50 companies, both large and small, that had formal programs on alcohol abuse in effect. Recognizing the lack of motivation to use the resources of alcohol abuse programs, Mrs. Mann struck out on a new trail, developing new methodologies and new delivery techniques. By 1965, there were close to 180 companies or agencies with programs in effect. However, the Department of Defense was not included at this time [3]. The Navy's primary treatment was admission to one of the Navy hospitals, usually in the Psychiatric ward where the doctors often knew less than the patient about alcoholism:

> "Treatment emphasis was on detoxification, medical management, psychiatric observation and whatever benefits could be derived from the hospital milieu."

There was so little understanding of alcoholism at this point, that there are numerous documented cases where sedatives were prescribed for the chronic alcoholic in an attempt to free them of the tension associated with the consumption of alcohol. The problem was that alcohol, by nature, was a depressant; therefore, the combination could have been quite lethal.

In 1965, a retired Navy Commander entered the dispensary at Naval Hospital, Long Beach, California, to address this problem of treatment and was referred to Captain Joseph J. Zuska, a staff psychiatrist, for further discussion. Commander Richard Jewell stated he was a recovering alcoholic and was literally saved by Alcoholics Anonymous (AA). His concern was that the Navy had not assisted his recovery program to any appreciable degree, but merely hospitalized him on no less than seven occasions prior to his introduction to AA. In not one instance did the Navy diagnosis his problem as chronic alcoholism. Captain Zuska's interest was nurtured by the prospect of possibly saving others who had been denied recognition and possible treatment of alcohol related problems.

Commander Jewell offered his assistance by proposing to conduct weekly AA meetings at the Long Beach Naval Hospital. Attendees were to come through a medical referral or from suspended sentences of non-judicial punishment of alcohol related cases. The first Naval Alcoholics Anonymous was held on 15 February 1965 with the Commanding Officer of Long Beach

Naval Hospital's support. As Captain Zuska relates, not all went well on their first time at the starting gate:

> "(It) took place with one alcoholic sailor, Dick Jewell, two recovering alcoholics from the community, and a practicing alcoholic Executive Officer of the station who dropped in out of curiosity and brought his two german police dogs. The picture of that first meeting is still vivid-Dick and his friends attempting to read from the Big Book, the intoxicated Executive Officer trying to direct the meeting, two huge dogs pacing rapidly about the room, and a bewildered sailor wondering what he had gotten himself into." [4]

The first 30 men who attended these meetings did not recover, a success story a bit underwhelming; however, the leaders were undeterred and continued to press on with the meetings in a small conference room at the hospital. After 18 months these meetings grew to 25-30 men with measurable results. Referrals for treatment were quickly increasing in proportion to the recovery rate.

Commander Jewell had made his point. Captain Zuska requested more area to hold the AA meetings from the Commanding Officer of the Naval Station. He was offered a small quonset hut as a classroom. It was here in August 1967, on an outpatient basis, that daily classes were held. It grew to 30-40 personnel in attendance, receiving lectures and holding group discussion meetings. The group eventually moved to an obsolete World War II barracks that had a large classroom and bedding for inpatient care as additional medical techniques were applied to the treatment [5].

Shortly after this move, the "Boot Legged" treatment program was finally approved by the Chief of Naval Operations as a pilot project under the Chief of Naval Personnel. No other commands were notified of the new program authorization. Due to lack of patient input and small staff, the output of improved patients was low, although proportionally successful in relation to the total. Discharge from the service for those who couldn't cope with alcohol was the norm Defense Department wide. The result was alcohol related disorders in Veterans Administration Hospitals doubled between 1965 and 1969, the growth period of the Vietnam War. The treatment center continued to press for recognition and sent a letter in early 1970 requesting the establishment of 5 Alcohol Rehabilitation Centers, including the one at Long Beach.

In May of 1970, despite the apparent success of the pilot project, the Chief of Naval Operations sent a response via the Bureau of Medicine and Surgery disapproving the installation of the 5 Alcohol Treatment Centers, but approving the establishment of a formal education program. Sources disagree on what exactly followed for the next year, but it is known the Long Beach treatment program continued to function with inpatient care.

C. CONCLUSIONS

During this period from 1965 to early 1970 the Alcohol Rehabilitation Program was simply not defined. The illustration

in Figure 1 is how the program appeared to the Navy. As a shapeless structure, it was not supported nor accepted by the organization. It had neither the people nor technology to establish itself. The Navy organizational environment was totally apathetic to its cause.

The Navy was unable or more likely, unwilling, to integrate this budding program with its current goals, which were:

> "To keep the seas open for commercial and military traffic of all kinds...[which is] sea control, and to make it possible to apply military power overseas...[which is] projection." [6]

The intrusion in the system by the group at Long Beach Naval Hospital, was tolerated because it was only a minor deviation from an established support system (Bureau of Medicine and Surgery) and placed outside its view.

It is easy to see why a program of this nature would be ignored when there is an abundance of manpower available. There is no reason to spend limited assets on social or rehabilitation programs when the environment makes no demands.

The task facing the leaders of the new alcohol treatment movement was to have an organization entrenched in tradition, rigid in structure and innovation, recognize a revolutionary idea that alcoholism was a disease and treatable for the thousands who were afflicted. In addition, the system was to provide the resources for treatment facilities and treatment personnel. It is quite obvious that many puissant forces had to occur concurrently before any movement toward recognition of alcohol abuse would take place.

THE BEGINNING

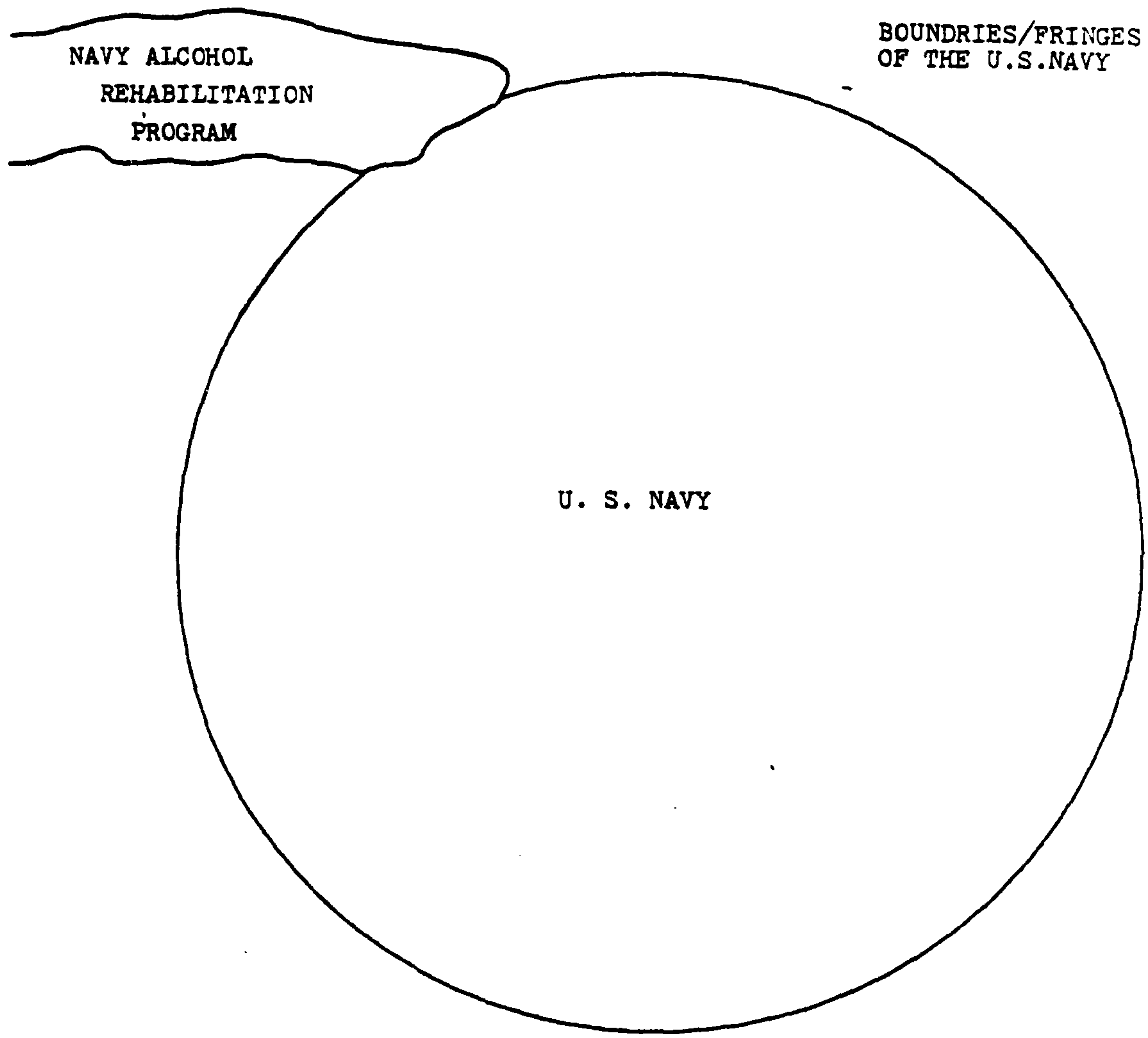

FIGURE 1

III. STIMULATION

"The hallmark of our age is the tension between related aspirations and sluggish institutions"

John Gardner

A. FORCES AT WORK

Through the late 1960's, not much had been done on the drug or alcohol issue except the traditional Federal emphasis on narcotics law enforcement [7]. Rehabilitation and education had been basically ignored.

In spite of the credible independent work in Long Beach, California, to establish a recognized Alcohol Rehabilitation Center, little progress had been made in regard to institutionalizing the program by the Navy. The rehabilitation work was carried on by recovered alcoholics as unsponsored crusaders. Without support, either external or internal to the organization, the program had little chance for survival. But as luck would have it, three major forces coalesced during 1970-1971 to permit rapid expansion and entrenchment of Alcohol Rehabilitation Programs. They were:

- The Vietnam War
- Selection of Admiral Elmo R. Zumwalt as Chief of Naval Operations
- Passage of Public Laws 91-616 and 92-129

Each will be explored in some detail.

The Vietnam War was the number one public concern of 1970, and was having tremendous impact throughout the stratum of our society. In addition to the armed conflict making daily news, there were other serious complications, that of drug addiction of the personnel serving in-country. Illicit drug usage had doubled every year from 1967 to 1969, and showed no signs of relief from this frantic pace [8].

In Senate Hearings chaired by Senator Harold E. Hughes in November and December of 1970, the representatives from each branch of the armed services testified on the depth and breadth of the problem. The outlook was not bright; it was clear that the abuse of drugs was reaching epidemic proportions [9].

According to a former White House staff member under President Nixon, the coup de grace to the lingering ignorance of drug addiction came in late 1970 with a Congressional trip to Vietnam. The final report verified all the fears of the public, there appeared to be widespread drug addiction among our troops. This, combined with the other reports, acted as a triggering mechanism for action. It became apparent that the drug abuse enigma was no longer just a law-enforcement problem, but required long range planning for education, prevention and treatment.

The President was particularly sensitive to this issue for two reasons. First, while campaigning in 1968, he had promised a strong law and order administration and linked

drug use and abuse to the rising rates. Failure to act on this issue now vividly before the public, would seriously damage his re-election in 1972. Secondly, President Nixon perceived this issue of widespread addiction of those serving in Vietnam as additional leverage for the moderates deepening drive to withdraw all allied forces from the country. This would have been a deathblow to the President's Vietnamization program.

The Domestic Council was asked by the President to look into the problem. They reported a profusion of drug abuse programs already in place, but so diffuse that they were all but ineffective. As a means of uniting this fragmented effort, the President issued an Executive Order creating the Special Action Office for Drug Abuse Prevention (SAODAP). It was later legitimatized by Congress through special Legislation, one of the few programs initiated by the President to pass unanimously.

The infusion of money into SAODAP was tremendous, a total of $260 million out of a $370 million anti-drug budget in the first year alone [10]. With dollars comes power. While most other programs were being cut back during this time period, the Drug Abuse Program, via SAODAP, was being launched as the newest of the Nation's social action programs. The result was quite predictable; Federal Departments and Agencies recast their new programs into prevention of Drug Abuse. The Navy was no exception, as will be addressed shortly.

The second major force, selection of Admiral Elmo R. Zumwalt as Chief of Naval Operations (CNO), was a surprise to most everyone in 1970. Admiral Zumwalt was selected over 33 of his senior officers for nomination. At 49 he was one of the youngest ever to serve as CNO. It was declared that he was chosen to help bring the Navy into the modern age. He was a non-traditionalist on his stand for programs for people. While the Soviet Naval threat was markedly increasing, our capabilities were in jeopardy, and not just in a shortage of hardware. First term re-enlistment rates were a shocking 9.5 percent in early 1970, the lowest since 1955 [11]. This was well below that necessary to man even a minimum fleet. With mounting anti-militarism of the generation that was to fill these shortages, there was little hope for an effective Navy in the near future if it continued business as usual. In addition, the end of the draft was in sight. Like it or not, the Navy would be all volunteer by 1973. His selection was preventive medicine for an ailing system.

Clearly, things had to change. Admiral Zumwalt provided the internal force for people oriented programs to be a reality. This included elimination of many unnecessary regulations and establishment of programs to assist active duty members with their personal dilemmas. The Alcohol Rehabilitation Program had received a powerful ally.

The third major force was external in nature. The concept of alcoholism as a genuine trouble spot in society has been very slow in developing. The stigma attached to the addicted drinker of alcoholic beverages was strong and deep. In 1948, 50 percent of the people surveyed nationwide by Rutgers University, believed alcoholics did not need treatment and could stop whenever they wanted. Some ten years later, in another nationwide survey, 58 percent of the respondents thought the habitual drinker was sick instead of morally weak as the first survey led one to believe. The slow shift was a result of repeated statements by three major organizations, the Yale Center of Alcohol Studies, the National Council on Alcoholism and Alcoholics Anonymous, that alcoholism was a treatable disease [12]. To the supporters of Alcohol Treatment Programs, this disease concept was fundamental for recognition of their activities. The confusion of whether alcoholism was a personality disorder, a physical illness, or a reaction to social status or structure, held up much of the research into treatment of those beset. Identified as a disease it would force physicians to gain knowledge and experience in treatment, induce hospitals to accept alcoholics for inpatient care and rehabilitation, expand research into the causes of alcoholism, and assist in the identification of those afflicted. This long war of recognition had few major successes until 1968 when President Lyndon B. Johnson stated before Congress:

"The Alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment. Even with the present state of our knowledge, much can be done to reduce the untold suffering and uncounted waste caused by this affliction." [13]

True recognition was a heartbeat away. The follow-up to this addressal, and another by President Nixon, led to enactment of Public Law 91-616, "The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970." The precedent established by this act permitted segments of the Federal Government to pursue programs on alcohol rehabilitation.

In 1971, a bill specifically directed to the Department of Defense was introduced as a rider to the Selective Service Act by Senator Harold Hughes of Iowa. It reads in part:

"The Secretary of Defense shall prescribe and implement procedures...to identify, treat and rehabilitate members of the Armed Forces who are drug or alcohol dependent."

It was called Public Law 92-129.

This was the leverage necessary to justify many of the programs in the Navy under design by recovering alcoholics.

It should be noted there was disagreement among the early alcohol program leaders on the importance of these public laws. It was felt by some that the program would have developed exactly the same way without Public Law 91-616 and 92-129, and that this leverage was not necessary. Others felt that these laws were pivotal.

B. USING THE FORCES

These three major forces merged within a 14 month period and provided the opportunity for tremendous advancement in recognition of Alcohol Rehabilitation Programs.

The problem facing those involved was how to use this boost advantageously. Taking on a remedial enterprise with zeal and enthusiasm is one thing; however, doing it effectively is something else.

As indicated earlier in this chapter, Admiral Zumwalt took his assignment as CNO in 1970. He recognized the drug and alcohol problems almost immediately, but did not yet have the financial resources to tackle the problem head on. Using manpower instead, he assigned one of his best officers, Captain Charles F. Rauch, as Special Assistant to the CNO and Project Manager of the Human Relations Project Office. In this capacity, Rauch was to coordinate the peoples program advancements proposed by the CNO. This included the Drug and Alcohol Program. At this point in time, the Drug Program had been formulated and open for business, but hardly what one would term, "established." The Alcohol Program was non-existent except for a few dedicated folks at Long Beach Naval Hospital. Rauch was introduced to an aggressive and dynamic officer (and recovering alcoholic), Captain James Baxter, who convinced him that the Alcohol Rehabilitation Programs needed recognition and leadership to get the project underway. With the CNO and the Chief of Naval Personnel's

approval, Rauch selected Baxter as the Navy's Alcohol Abuse Control Program's (NAACP) first Director. To get the Program launched, 50,000 dollars was procured from the Naval Material Command and they established an office in a little used building at the Washington D.C. National Airport designated as T-7. During the move to his new office Captain Baxter was joined by two other recovering alcoholics and a disenchanted non-alcoholic secretary who believed this job had to be better than her last. Although this does not appear to be the solid support necessary to create a visionary program, the atmosphere was just beginning to clear for the Alcohol Program supporters.

The first big hurdle had been cleared. Due to the change in leadership within the Navy, the internal force for reformation had been strong enough to permit the crusading Alcohol Rehabilitation personnel to get a foot in the door. Admiral Zumwalt had identified Drug and Alcohol Rehabilitation as one of his goals in his charter of the new peoples programs. For the next 6 months, creative methodologies abounded to foray money from the Drug Program, which was gaining an infusion of dollars as the SAODAP program was developing. With this financial backing, the office grew and began designing their future. Captain Baxter, as the senior zealot, preached to all who would listen about the developing program. He met with Captain Joe Zuska and Commander Dick Jewell of the "unrecognized" Navy Alcohol Treatment Center in Long Beach,

to review their steps to alcohol recovery that had been so painfully acquired over the last 5 years. With their expertise and guidance, a model was formulated for additional treatment centers if the idea could be sold the Navy hierarchy.

Despite recognition by top management, no major innovations or developments had been instituted yet. The growth and expansion of the program was promising, but still tenuous.

In September of 1971, Public Law 92-129 was passed by Congress. In addition to directing the Secretary of Defense to implement the Programs, it gave a deadline of 60 days for action. The Alcohol Program personnel were well prepared and now had reason to be truly optimistic about the future.

C. CONCLUSIONS

Alone, alcohol issues were still not a major public concern despite its widespread misuse. Illicit drugs on the other hand were apparently of grave concern. This split was at odds with logic. The difficulty was the perception of the problem.

Illicit drugs were a mystery to most of the middle to upper age brackets in this country. It was difficult for them to relate to a heroin addict, but probably a little easier to understand an alcoholic since most had witnessed alcohol abuse at some point in their lives. In addition, alcohol was a legal substance.

In reality, drug abuse involves both illicit substances and alcohol. The division has partly been for identification for law enforcement. The moral issues will not be addressed here; however, effective rehabilitation often includes the same model in addiction to either substance. The attention given to heroin abuse in Vietnam was indeed one of the catalysts for recognition of the alcohol problem. It appears the Alcohol Rehabilitation Program had to ride in on the coattails of the Drug Rehabilitation Program if it was to get started at all.

For better or worse, the Department of Defense has usually been on the frontier of change on social policies. This is true for a number of reasons, not the least of which are that the military can be tightly controlled and changes can be made unilaterally. All that is necessary is the proper support from the hierarchy, and the external pressure for change. During 1970-1971, the Alcohcl Rehabilitation Program had made major inroads to acceptance of its existence. It had penetrated the organizational sphere of the Navy as illustrated in Figure 2. But it was far from developed as a sub-unit.

The program was permitted to formulate under the direction of Admiral Zumwalt, but it was necessary to use the external forces of the Vietnam War and two Public Laws to legitimize its presence. Nor was the sub-unit well-defined.

STIMULATION-FORCES AT WORK

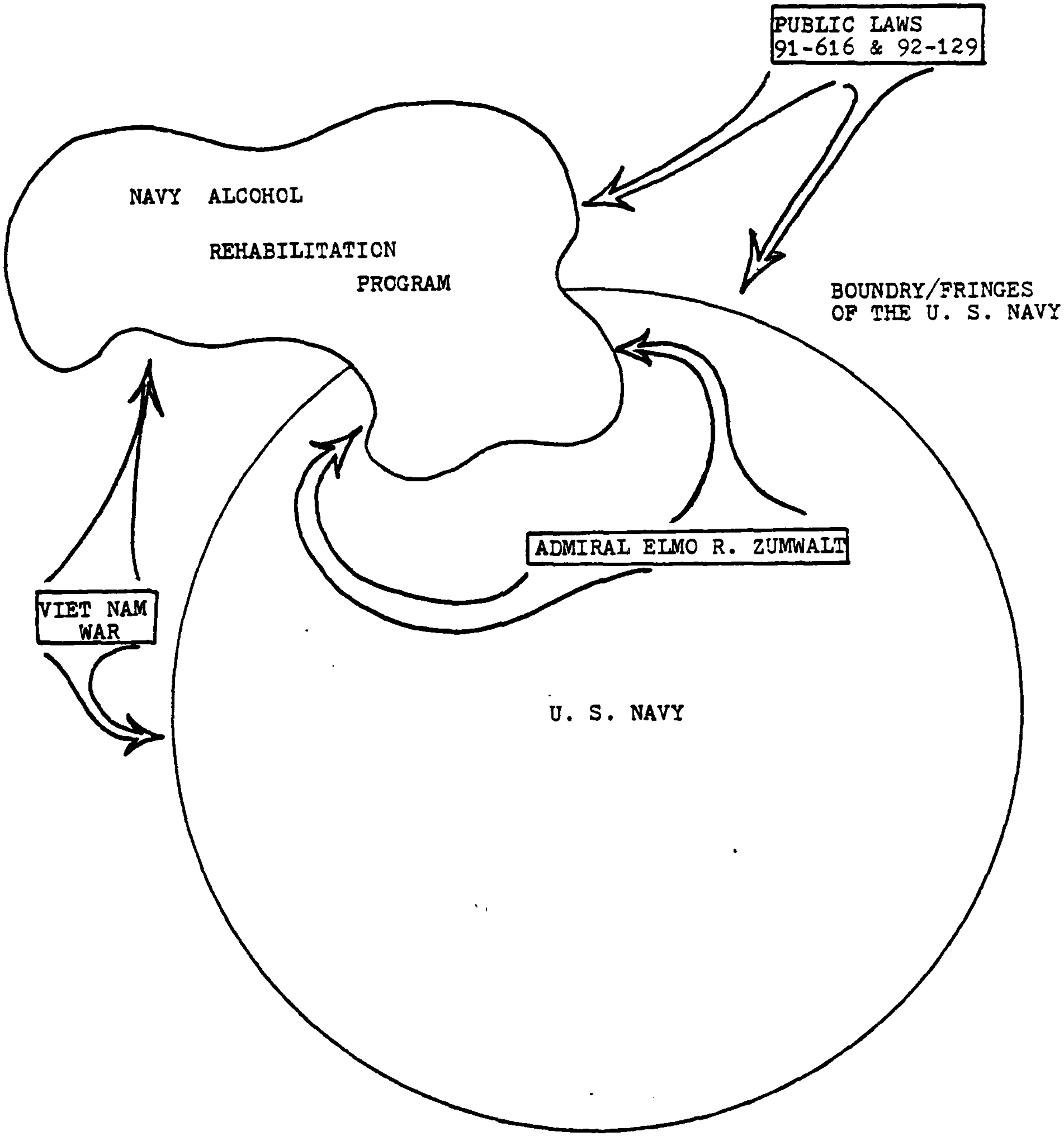

FIGURE 2

It had an office, but was in a project status. No one was quite sure what it was really supposed to do. It had the flexibility to cross lines of authority throughout the Navy to publicize its development but could not produce an approved timetable for installation of various aspects of its program. Even the technology of the program was ill-defined. The ability to treat those addicted to alcohol had only been proven on a small scale. What would happen when hundreds a month, all across the country, would enter the program?

As those in the program recognized, the next step was to solidify its standing with the Navy to enable it to resolve the numerous problems. To ensure its assimilation into the organization it must take additional steps. Section IV will chart the course taken for the remainder of 1971 to the first part of 1974.

IV. DEVELOPMENT (1971-1974)

"If the shoe fits, you're not allowing for growth"

Robert N. Coons

A. INTRODUCTION

What eventually forced the issue of recognition of the drug problem in this country was the perception that it was rampant throughout the Armed Forces. The public demanded action and the pressure for treatment and education programs was high.

The military was in the forefront of the effort to address the drug problem. As the Navy responded, some recovering alcoholics on active duty (most schooled by Alcoholics Anonymous) recognized this as an opportunity to expand their work, much like an evangelist in a tribe of heathens. Their job was to convince the Navy that alcohol abuse was at least as bad as the public's perception of illicit drug use, if not considerably worse.

These men were the pioneers of the new wave of rehabilitation efforts. They also were strong supporters of Alcoholics Anonymous's twelfth step (Appendix A), that of helping others with the same disease. This is a very important point. They were the zealots and torchbearers of the way to recovery.

They used the Navy as much as the Navy used them, both to their mutual benefit. This was particularly important in the years to follow, which will become clear in this Chapter.

B. THE TURBULENT YEARS

As stated in the last chapter, the Navy had actually begun developing its Alcohol Rehabilitation Program prior to Public Law 92-129 as a result of Admiral Zumwalt's Human Goals Program. The Alcohol Program was, in fact, just one aspect of this. The Human Goals Program also included race relations, drug abuse, overseas diplomacy and organizational development. Support by the Chief of Naval Operations was assured if the Alcohol Program could prove its worth.

Upon opening their doors in August of 1971, the official priorities for the young Alcohol Program were mixed. It is speculated that certainly a major issue was the establishment of the program as a true part of the Navy's support group. Resources were extremely tight as evidenced by the limited available manpower. Virtually all the funding came via the Chief of Naval Personnel (CNP) vice the Medical Department, Bureau of Medicine and Surgery (BUMED). This is surprising since much of the enlightened recognition of alcoholism as a disease came from the American Medical Association, which recognized it in 1956 [14]. As will be evidenced through these turbulent years, the program received little continuing support from BUMED.

Other transitional problems were coming to light. The original intention of the organization was to combine alcohol and drug abuse under one Director according to early Bureau of Naval Personnel (BUPERS) documents. The desired consolidation of management efforts did not come to pass until years later. At first glance, it appears that the Alcohol Program would be accelerating its own demise by cutting itself from assured funding. But to the Alcohol Program leaders, there was a distinct methodology to their apparent suicidal tendency. First, the personnel assigned to the Alcohol Program were truly crusaders for rehabilitation. All had experienced the horrors of alcohol dependence and worked their way back to a normal life. This was not true of the drug rehabilitation supporters. Virtually none of these were ex-users of illicit drugs. The motivations for success were simply not the same. Secondly, the average age of the alcohol addicted patient was close to 30 years, and characteristically career oriented in the Navy and with a family. The drug addicted patient was considerably younger, closer to 20 years old, without ties or established loyalty to the organization that was attempting to treat him/her. The investment by the Navy in training was usually not very high. Moral issues aside, it may not have been as cost effective to rehabilitate a younger drug abusing sailor. Third, alcohol was legal while drugs generally were not. This brought in the punitive issue. Politically it was much easier to work with rehabilitation of legal

substance abuse than illicit drug abuse. Fourth, the Alcohol Program Director was very senior and had direct access to Rear Admiral Rauch, the Special Assistant to the CNO and Project Manager of the Human Relations Project Office. This resulted in little coordination with the Drug Rehabilitation personnel. As a result, the leaders of the Drug and the Alcohol Programs did not work together; each worked their own program and own goals. The Alcohol Program desired no association with the Drug Program. Each went about their own business as two unattached entities in the Human Relations Program, and it continued that way until 1978.

Throughout these formative months, the cross walking of funding becomes very confusing. Much was taken from the Drug Program since it was getting an infusion of funds, and more was acquired through "creative procurement." No one truly remembers where it all came from; it must have been a most interesting time.

Meanwhile, the alcohol people continued their drive for recognition. The first Alcohol Rehabilitation Center was Captain Zuska's operation at Long Beach Naval Hospital. It was officially recognized in August 1971. Designated as a BUMED function, it forced continued participation of the reluctant Medical Department.

By October of 1971, the NAACP personnel had their Alcohol Program guidelines before the CNO. In thirty days the CNO had approved the plan, in principle, to be developed as

appropriate instructions and directives. In addition, he approved the establishment of an Alcohol Rehabilitation Center for the East Coast to be located in Norfolk, Virginia. Unlike the first ARC in Long Beach, this was under the Chief of Naval Personnel. This brought the operational wing of the Navy into the alcohol rehabilitation business. Now both the Medical Department and Line (operational Navy) were responsible for treatment programs. The operation of both clinics was basically the same. Utilizing Captain Zuska's model of a multidisciplinary blend of medical treatment, group therapy, education, spiritual reinforcement, and individual counselling, they stimulated a desire in the patient to develop a personal program of recovery. They relied very heavily on Alcoholics Anonymous for continued support. It was inpatient treatment for 6 weeks in both Centers. The Norfolk Center proved as successful as the Long Beach one.

The Navy's para-professionals running the Program were largely recovered alcoholics. This is one of the major differences between the Navy's program and those of the Army and Air Force. The Army/Air Force approach was centered on the professional treatment specialists, those schooled in rehabilitation efforts, but not experienced as a student. This is to say that the Army and the Air Force rejected the idea of recovered alcoholics helping alcoholics. The Navy on the other hand, insisted that utilizing recovered alcoholics was the only sensible approach. Not only were the leaders

and majority of the personnel in the Alcohol Abuse office all recovered alcoholics, but most of the Alcohol Abuse Counselors were also. In addition, a referral network (REFNET) of treated alcohol abusers was kept by the Program. They were utilized for local command coordination of possible alcohol abusers, education of command personnel, and visible proof that recovered alcoholics could lead full and productive lives. As a result, the Navy far outdistanced both the Army and Air Force in those early years in establishment of working treatment programs.

Early in the Program, the NAACP knew how to employ the Program to meet the ends of the Navy to obtain at least minimal support. Since the Navy was an institution supported by tax dollars and highly vulnerable to public opinion, it had a paranoia about cost effectiveness. If a program did not pay for itself in some manner, be it increased defense capability or increased effective manpower, it was in a very tenuous position for survival. The NAACP office took steps from the very beginning to validate its cost. They could present an imposing set of in-house cost effectiveness studies based on the success rate of rehabilitation. The criteria for success was self-generated in these early times. This is not to state it was incorrect, but simply that the program was self-evaluated for a number of years. There is no evidence of resistance to these studies from any other source

and no other models of "successful rehabilitation" surfaced to challenge NAACP's. The program declared it was more than paying for itself, and there appeared to be no argument.

Through 1971 and 1972 the goal developed by NAACP was to "save lives." As viewed by the program leaders, recovery was most effectively accomplished through treatment centers. The drawback, as recognized by NAACP, was that the majority of the funding was placed in treatment centers instead of education.

This brings to light the classic argument of where to start a program designed to terminate abuse. With limited resources, it is impossible to effectively educate personnel to prevent abuse and rehabilitate personnel who already are abusers. The early decision was made to orient the program toward rehabilitation of those who were abusers. "Save lives" meant rehabilitation centers, and 85 percent of the funding went to that goal. More importantly, the scarce billets (authorized assignments of Naval personnel) were primarily treatment oriented. Occasionally, bursts of money came through for education issues, but no ongoing education was designed by 1972.

Support continued to mount for justification of the Alcohol Program. In March of 1972, the Department of Defense issued Directive 1010.2, "Alcohol Abuse by Personnel of the Department of Defense." It preceded a flood of similar instructions by the Secretary of the Navy, Chief of Naval

Operations (message Z-115), Bureau of Naval Personnel and Bureau of Medicine and Surgery. All helped to identify alcoholism as a treatable disease and pointed the way for Naval Commands to follow for alcohol rehabilitation.

By the end of 1972, a third ARC had opened in Great Lakes, Illinois. Other milestone events of significance were:

1. The tremendous number of briefings held for senior officers in all types of Commands on alcohol abuse.

2. A CNO SITREP film on Alcohol Rehabilitation was produced, distributed and shown Navywide.

3. "Chalk Talk on Alcoholism" by Father Martin, a classic in alcohol abuse films, was distributed throughout the Navy.

4. A survey to follow-up on all treated patients every 6 months for two years to monitor their progress, was initiated.

5. Establishment of a referral network of recovered alcoholics who have volunteered to assist the Program by helping the Commands they were currently assigned. This volunteer program was very important to the education program started in 1973.

6. Opening of the first Alcohol Rehabilitation Unit (ARU). It was at the Philadelphia Naval Hospital and under the control of BUMED. All ARU's were placed in Naval Hospitals. The program treatment parallels that of the ARC's.

It was a banner year for the program. The tremendous success continued through 1973. Among the accomplishments were:

1. A continued growth in the recovered alcoholic network program.

2. A comprehensive conference of all the Navy's Colleral Duty Alcohol Counselors was held; the first of its kind

in the Armed Services. Among the speakers were Mrs. Marty Mann, founder of the National Council on Alcoholism, Major General J. K. Singlaub, a Deputy Assistant Secretary of Defense and Vice Admiral R. B. Baldwin, Deputy Chief of Naval Personnel.

3. The fourth ARC was established in Naval Station San Diego, California.
4. The first Alcohol Rehabilitation Drydock opened in at Naval Station Roosevelt Roads, Puerto Rico. Drydocks were usually an outpatient local rehabilitation unit for less serious cases of alcohol abuse.
5. The Alcohol Training Unit (ATU) was established at the ARC San Diego to conduct education and training for service personnel in all phases of alcoholism prevention and rehabilitation.
6. Operating ARU's have expanded to 14 under BUMED control. This was in addition to the 4 ARC's under BUPERS.
7. Billets were available to fill all Human Resource Management Centers (HRMC's), then lost due to billet restructuring. These billets were for Alcohol Abuse Control. This was one of the few serious setbacks in the first three years of operations.
8. The official name of the alcohol program was changed from Navy Alcohol Abuse Control Program (NAACP) to Navy Alcoholism Prevention Program (NAPP). It is speculated that possibly one of the reasons for change was to avoid

confusion with the National Association for the Advancement of Colored People (NAACP), but more likely was to insure the word "prevention" appeared.

9. BUPERS fully funded BUMED's Medical Officers for attendance to an American Medical Association conference on Alcohol Abuse and Alcoholism.

In addition, one of the most significant accomplishments of 1973 was the issuance of OPNAVINST 6330.1 in May. It was an instruction to all the Navy titled "Alcohol Abuse and Alcoholism among Naval Personnel." It stated in part:

> "An initial BUPERS-sponsored survey of active duty personnel shows a need for concern over the relatively large percentage of officers and enlisted members who have experienced unfavorable social consequences, behavior problems, impaired performance of duty, damage to health, injury, or financial and family problems, related to drinking. These habitual alcohol abusers may be alcoholics or potential alcoholics. Alcohol abuse and alcoholism to any degree constitutes an unacceptable loss to the Navy in training, investment and operational efficiency and a high cost in resources and human suffering."

One of the most important issues addressed through this instruction was that of establishment of education and training programs. Support had now gone full circle. Education was to receive attention as the means to avoid the continual necessity to build additional ARC's and ARU's. Through these and additional guidelines formulated earlier in the program but never used, NAACP moved to initiate an elaborate education network.

With monthly referrals into the rehabilitation system over double those in the late part of 1972, it was recognized that prevention was the key, and this would come about primarily through education. As stated by one of the Commanding Officers of an Alcohol Rehabilitation Center:

> "When we're dealing with alcoholism we are dealing with a person already fallen to the bottom of the cliff... what we want to do is build fences at top to avert falling...that is prevention."

All that remained was the method. The model that was decided on was already in place at the Department of Transportation. Work was begun to make it a reality.

C. CONCLUSIONS

The task for these turbulent years for the Alcohol Rehabilitation Program was three-fold:

1. Develop the Program quickly.
2. Protect what has been accomplished.
3. Formalize the Program.

As illustrated in Figure 3, the program had taken form and almost been assimilated into the Naval organization by 1973. The problems facing NAACP in accomplishing their task were typical of any new project; i.e., dollars and recognition.

Like most large organizations, the Navy has major departments competing for scarce resources of manpower and money. These departments, surface, subsurface and air are all very powerful. They are the operational end of the Navy, termed

DEVELOPMENT

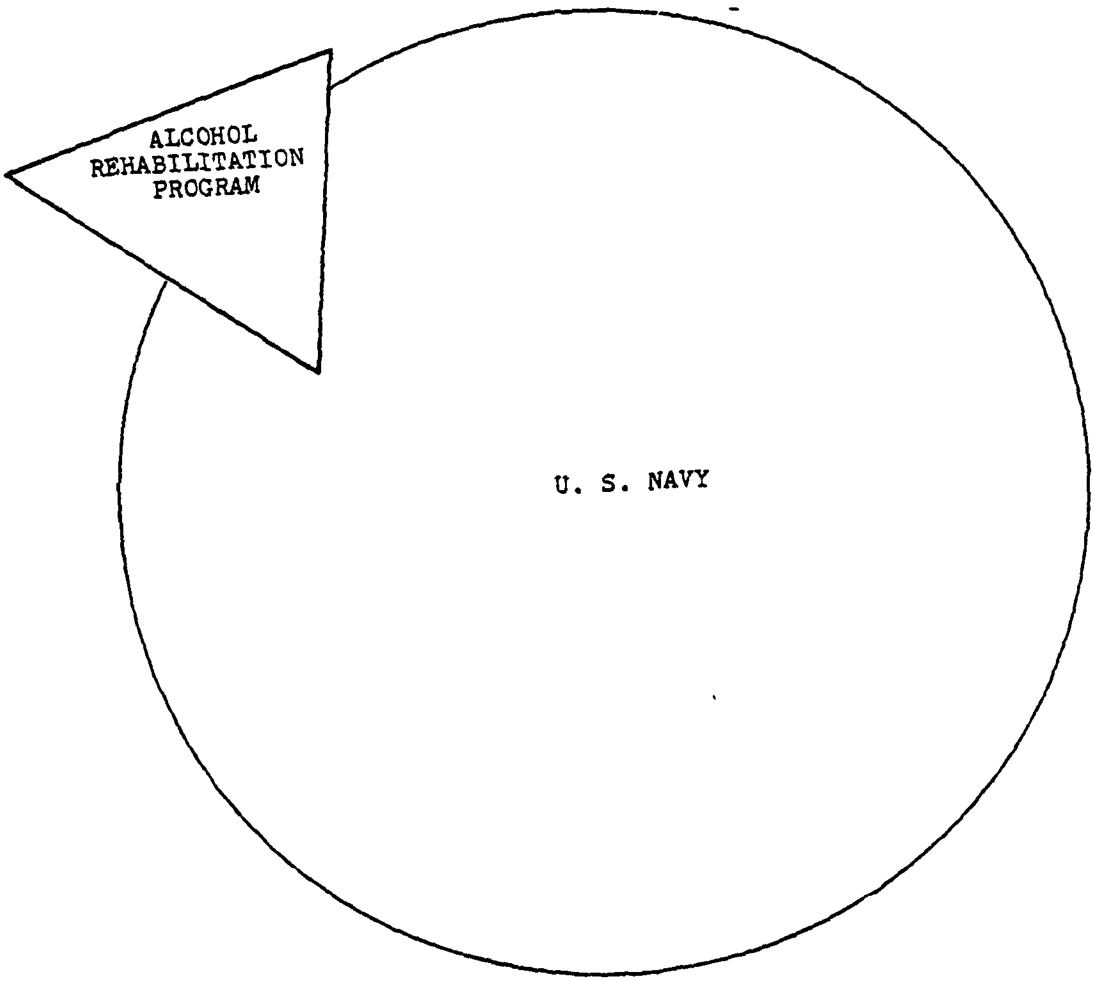

FIGURE 3

"Line." There are never enough dollars to buttress them all as they desire, therefore, difficult compromises must be made in accordance with the parent organizations' ultimate goals. For support sub-units and programs to survive, sacrifices must be made by the major departments. This brings us back to justification or cost effectiveness of the program under scrutiny.

In this case, the leaders displayed their cost effectiveness continually. Figures showed the entire HRM Program could have been cost supported on the success of the Alcohol Rehabilitation Program alone. More importantly, these figures were believed by the CNO. This assured the latitude for the completion of the first task, develop the program quickly.

Virtually every step was *cost effective* to the Navy according to Alcohol Program leaders, and the various levels of command were all briefed to that effect. It follows then, by building a firm foundation of support it will assist the second task, to protect what has been accomplished. The new program was allowed in, and was now fenced with money and manpower (although still limited). The budget for fiscal year 1973 was 5.5 million dollars, a far cry from the 50,000 dollars used to get the program started.

The third task, that of formalization was fulfilled through a myriad of instructions from all levels of the Navy, and development of a formal chain of command. The program was currently under development to be absorbed

permanently under the Assistant Chief of Naval Personnel for Human Goals. This was finally completed in early 1974.

The Alcohol Program was in the unusual position of controlling its own destiny at this time. It was still young and restless, with highly motivated and vocal zealots controlling its growth. There is little doubt they were highly innovative. The lack of control over the Program by the parent organization was tolerated in these early stages. The members involved had very specialized skills and their commitment to the alcohol rehabilitation movement was never in doubt. They caused little disruption of the system as a whole and, in fact, provided an outlet for unit Commanding Officers to send many of their problems.

While survival was slowly being assured, there were changes that would have to be made for total integration into the Navy. This is the subject of the next chapter.

V. GROWING UP (1974-1977)

> "When I am grown to man's estate
> I shall be very proud and great
> and tell the other girls and boys
> not to meddle with my toys"
>
> Robert Louis Stevenson

A. INTRODUCTION

This period from 1974 to early 1977 was an extremely critical time. While well established in the field of treatment and still expanding, alcohol abuse education was seen by the Alcohol Program leaders as the Program for the future. Treatment centers were overflowing with patients, and the waiting lists were getting longer. What was recognized was that little was being done in prevention of abuse and ultimately prevention of the influx of personnel into treatment. One result of this concern was development of the Navy Safety Action Program (NASAP). It was patterned from a current education package in the Department of Transportation.

As an interim means to solve the shortage of spaces in the ARC's and ARU's was the expansion of a program called Drydock. It was a local program for local commands to treat less serious cases of alcohol abuse. It was in place in 1973, but true recognition and funding took place in 1974, by the Chief of Naval Personnel.

It was also during this time that the Alcohol Abuse Program was totally integrated into the Navy structure. It had become a formal sub-unit and was adapting to the Navy way of doing business. But the leaders of the Alcohol Program were still far from being average Naval Officers. They continued to be aggressive and sometimes abrasive in promotion of their programs. Their effectiveness was spectacular.

B. GROWTH

It would have been a pleasure for the Alcohol Program personnel to state they had convinced all commands that the Program was an answer to their problems. Such was not the case. Much support had been gained and their reputation was excellent. However, as Dr. Zuska relates, the Program still had some problems:

> "One follow-up letter from the Commanding Officer of a ship complimented us on having cured a petty officer of his alcoholism because 'one of my officers tried for four hours to buy him a drink and he refused.' The letter was forwarded to the Chief of Naval Personnel as a example of dubious support for a recovering alcoholic." [15].

People knew of the Program but did not yet understand alcoholism.

As stated in the last chapter, the Navy recognized the means to slow the building tide of referrals to ARU's and ARC's, was through a prevention and education program. It was assumed that education was a method of prevention. That if the abusers knew what the alcohol was doing to their

body and mind, they would rationally avoid abuse. This may not always be the case and some studies have refuted this technique and the assumptions that nonabuse is educable. But the true results of their efforts would not be seen for years, but it was felt the attempt had to be made.

The impetus for starting the Prevention Program was OPNAVINST 6330.1. It stated in 1973 that the Naval Safety Center was tasked:

> "in conjunction with CHNAVPERS...(to) conduct direct liaison with appropriate officers of the U.S. Department of Transportation aimed at developing Alcohol Safety Action Programs (ASAP) for implementation at all Navy shore installations."

To understand the development of this Program, it will be necessary to reflect a bit. The Highway Safety Act of 1966 required the Secretary of Transportation to complete a study of the relationship between the consumption of alcohol and highway safety. Two years later the startling results were that the use of alcohol led to 25,000 automobile related deaths and at least 800,000 automobile collisions in this country a year. The National Highway Safety Administration was tasked to take action. The result was a program funded through the Department of Transportation called the Alcohol Safety Action Program (ASAP). There were eventually 35 ASAP's established throughout the country. The Program was one of cooperation with the courts for alcohol related traffic offenses and development of a school for drivers convicted of driving under the influence of alcohol. Diagnosis was

made to determine if a driver was a problem drinker and check the degree of involvement with alcohol. Referrals could then be made to local hospitals, or rehabilitation units, if necessary [16].

The Navy recognized this as a program it could use to initiate its own prevention and education service. Prevention was defined as possibly educating the alcohol abuser prior to his becoming an alcoholic necessitating treatment at an ARC or ARU. Education was being an awareness of the disease of alcoholism and where it ultimately leads. The NASAP program does even more than this, which will be addressed shortly.

A Navy ASAP planning committee was devised to formulate the program. It included representatives from the Navy Safety Center, BUPERS, National Highway Traffic Safety Administration, the Fairfax Virginia ASAP and one representative from an ARC and one from a Human Resources Management Center. The program was to be called the Navy Alcohol Safety Action Program (NASAP).

Even with this, funding and personnel support was difficult to acquire. It required the alcohol program leaders to again apply "creative procurement" techniques and secure a billet from the Chief of Naval Education and Training through their Navy Education and Training Center. A retired LCDR, George Gilpin, was picked as the first officer in charge

of the project in Pensacola. He previously worked at the CAAC there, and had experience and contacts throughout the Pensacola area.

Commander G. R. Bunn was assigned to put the program together. He commuted from his office in Washington D.C. to Pensacola, and designed the program with Gilpin.

It was realized early by these coordinators of NASAP, that they were getting into an arena of specialized instructional skills necessary to pursue the prevention process. Academic expertise was necessary if this were to be a successful endeavor. The University of West Florida, located in Pensacola, was brought in through Philip E. Bromley, PhD. This was the academic capability needed to design the nuts and bolts of the curriculum.

By March of 1974, the efforts were formally recognized in a message from the Chief of Naval Personnel to the Chief of Naval Education and Training stating:

> "...that NASAP is one of the solutions to the problem drinker/alcoholic...(and it is desired) to establish (a) pilot NASAP in the Pensacola area. (The) entire project will be funded by BUPERS through FY 76."

Assistance for development for NASAP would be through administration and training by the Department of Transportation and the National Institute on Alcohol Abuse and Alcoholism for the first three months.

The project site, Pensacola, was chosen for a number of reasons. First, the only Alcohol Rehabilitation Drydock (ARD)

in the continental United States recently opened in Pensacola. Secondly, Florida was very pro-active and very supportive of alcohol abuse programs. This was very necessary for court referrals to the Program. Thirdly, the University of West Florida was available for academic support. Finally, Pensacola was a relatively stable area for active duty service members. Units did not deploy as done in other large Naval installations so follow up investigations could be done easily.

Agreements were established with local county courts and the State of Florida Probation and Parole Office for liaison if a Naval/Marine active duty member were cited or arrested for alcohol related incidents. In most cases, after civil screening, the individuals apprehended were to be referred to NASAP for prevention education and additional screening. Court referrals began in August 1974 and the first NASAP class started September 1974.

It was a 36 hour, 6 week program done in the evening during the service members non-working hours. The goals and framework for NASAP appear in Appendix B. Literally hundreds went through the Program as a pilot project. It proved so successful that in 1976 a formal request for expansion was sent to the Chief of Naval Personnel Operations. Eleven sites were immediately approved.

As ultimately developed, the University of West Florida was contracted to provide all activities relative to educational screening, classroom coordination, education records, and facilitation of the actual classes.

With NASAP designed to assist eventual reductions in necessary referrals to overflowing ARC's and ARU's, an interim program currently in place, was expanded to relieve the lengthening, waiting lines for treatment. The Program was called Drydock. This should not be confused with a Drydocker program started by Dr. Zuska's treatment center in 1965. That was groups of treatment program graduates starting local Alcoholic Anonymous meetings wherever they were currently assigned.

Drydocks were to be sponsored by BUPERS, acting jointly with major operational commands to allow the smaller commands under their jurisdiction to rehabilitate less serious cases of alcohol abuse, on site.

In a speedletter sent by Rear Admiral Rauch in August of 1974, it was declared that new funding was available for 26 additional sites (added to the 4 currently in place). It allocated up to 20,000 dollars annually per site, plus billets for trained counselors if none were available at the local command. What was significant about this development was the attempted integration of some ARD's into Counseling and Assistance Centers (CAAC). At this time CAAC's were primarily designed for drug abuse counseling. The Alcohol Program was moving to integrate the services of drug and alcohol abuse programs. It is speculated this was not necessarily to streamline the abuse efforts, in light of the feelings the alcohol abuse personnel had for the drug abuse personnel, but rather

to stretch available alcohol program funds as far as possible. This is the first overtly combined effort of Drug and Alcohol Abuse Programs found.

The treatment at Drydocks was similar in format to the programs at ARC's and ARU's, only abbreviated. It provided for 2 weeks inpatient care, 4 weeks where the patient would spend a half a day at work and a half a day at the ARD. Following the sixth week there would be an additional 10 week follow-up with once a week sessions for the patient with a counselor.

It was for those less serious alcohol abuse cases this was designed. The local commanders now had a program of their own. The limited information available indicates that this Program was also very successful.

The year turned out to be a very good one for the Alcohol Program. Other significant events in 1974 were:

1. The ARC in Jacksonville opened, bringing the total treatment centers under BUPERS control to 4.
2. "The Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment and Rehabilitation Act Amendments of 1974" was signed by Congress. It authorized a total of 361 million dollars to be used by the Alcohol Abuse and Alcoholism Programs nationwide through 1976. This was a significant increase over previous Federal funding, but it still trailed drugs in total funding.

3. ARC Long Beach was transferred to Naval Hospital Long Beach and designated as an ARU under BUMED. It had previously been under BUMED but nonetheless designated as an ARC because it was not established in the hospital.
4. Increased pressures from major commands on subordinate commands to deemphasize the use of alcohol. For example, in early 1974 the Commander in Chief, Pacific Fleet, sent out a personal letter to all his commanders, commanding officers and officers-in-charge, to review management policies in clubs and messes. It directly referred to deemphasizing practices which may lead to overindulgence such as drinking contests, two for one drinks to a single customer and last calls designed to promote last minute sales. The Commander in Chief of the Atlantic Fleet sent out a similar request for review by message in September 1974.
5. Expanding cooperation by large commands. This was reflected by their requests for workshops and presentations on alcohol abuse. One such example was the Chief of Naval Air Training's request for alcohol abuse presentations from the NAPP office in Washington D.C. for his Training Wings in south Texas. It covered senior officers, flight instructors, flight students and enlisted members of the Wings. All were well attended.
6. The Alcohol Rehabilitation Program was removed from a project status in concert with the Human Goals Program. This meant that billets and funds were no longer fenced.

Things did not appear to open well for the Navy's Alcohol Programs in 1975. A Navy contracted study called "Final Report on a Service Wide Survey of Attitudes and Behavior of Naval Personnel Concerning Alcohol and Problem Drinking" was submitted to the Chief of Naval Personnel. It was done by the Bureau of Social Science Research, Inc. (BSSR). It had been conducted to accurately determine the scope of the alcohol problem in the Navy to permit projections of the programs for the future. In addition, it was to assist the Navy in pinpointing major causes of alcohol abuse. Jack Anderson, a well known syndicated columnist, obtained a copy and wrote an article citing the report. The title was "Drunken Sailor Image Seems True" and the inference was that little was being done to rectify the problem [17].

The report did show a very high alcohol abuse rate among Navy personnel, and did pinpoint the problem areas as originally intended. The negative publicity, however, was a two-edged sword. It also supported the alcohol programs contention that alcohol abuse was a truly significant problem in the Navy.

Quickly on the heels of this study was another by the U.S. Government Accounting Office on a comparison of the military's Drug and Alcohol Program. It showed the need to recognize alcohol abuse as the number one drug problem [18]. This was the same call voiced by a special committee in the American Medical Association (AMA) in the middle of 1975.

With this kind of documented support, the Alcohol Program was able to hammer home the issue of alcohol beverage sales and service. It called for and received:

1. Elimination of miniature and pint bottles of alcohol in all Navy Package stores under the notion that they could be conceivably be concealed by the patron at work.

2. All bars and lounges, and other alcoholic beverage retail outlets in the Navy, must have coffee and soft drinks available. In addition, all of these establishments open during noon hours, must have food service.

3. A requirement for all messes to provide family oriented facilities that are not centered around the bar/cocktail lounge.

4. A reduction of Happy Hours to once a week.

As the Alcohol Program entered a new year, 1976, it was on solid ground. It had been hit with cutbacks in personnel, but this was Navy wide. Most support groups were suffering from similar cuts due to overall budget reductions. By 1976, over 51,000 resident and outpatient personnel had undergone treatment. Clearly the Program was established. The budget for alcohol programs had climbed to over 8.8 million dollars a year. By the end of the year:

1. Twenty-six alcohol education/training seminars were conducted in the field for over 2,000 Naval Commanding Officers, Executive Officers, Navy Lawyers (JAG), and Medical Officers.

2. The Chief of Naval Education and Training, integrated alcohol and drug education into all Naval schools under it's command.

3. As stated earlier in this chapter, NASAP was expanded to twelve sites.

4. Forty ARD's were open and operating, all funded by BUPERS.

It is interesting to note that all 14 ARU's in place in 1976 under BUMED, were partially funded by BUPERS. In addition, a new program just getting underway with Medical Officers attending a two week course on alcoholism at ARU Long Beach, was funded by BUPERS.

The major setback for the year appears to be the closure of the ARC at Great Lakes. A Congressional report stating the Military had too many counselors was released. The report included counselors at ARC's and Drug Rehabilitation Centers, as well as unit career counselors, staff chaplains and psychologists. This was one of many times the Congress had raised the issue of excessive counseling, but this required action by the Navy. It demanded visible cuts of personnel in these positions. The Alcohol Program was no exception, and was told to reduce counseling billets. The feeling among the leaders of the Program was that a worldwide, across-the-board reduction would weaken the Program far worse than the alternative they ultimately selected. The decision was made to close a center despite the backlog of patients. The extra personnel gained from the shutdown of ARC Great Lakes would be used in other capacities; however, a number remained to give the Program flexibility to assist NASAP and other new ideas.

The first few months of 1977 were relatively quiet, but major changes were in the wind. There was much talk of combining Drug Abuse and Alcohol Abuse into one office and a

major restructuring of BUPERS appeared imminent. The effect of these, and other changes on the Alcohol Program, already institutionalized by the Navy, will be reviewed in the next Chapter.

C. CONCLUSIONS

It was during this period that there was full assimilation of the Alcohol Program into the Navy. The Program had become relatively immune to the environment external to the Navy. This means that the suffering of budget cutbacks, etc., was generally directed to the entire Navy and the Alcohol Program must only pay its fair share instead of fighting for survival. The assimilation of the Program is illustrated in Figure 4. The only external environment it must now realistically worry about is that of the Navy itself.

There was little doubt the Program fought hard to validate its worth and publicize its services Navy wide. It responded to Congressional calls for Alcohol Rehabilitation Programs for the Navy, and managed to stay at least one step ahead of Alcohol Program demands placed on the Navy by the Department of Defense. Despite a reduction in manpower and a shortage of trained counselors, it proved to all who would listen that the Alcohol Program was assisting the Navy. It had claimed it had rehabilitated thousands of well-trained personnel and returned them to duty, saving the organization millions of dollars annually. It flew to Naval commands

GROWING UP

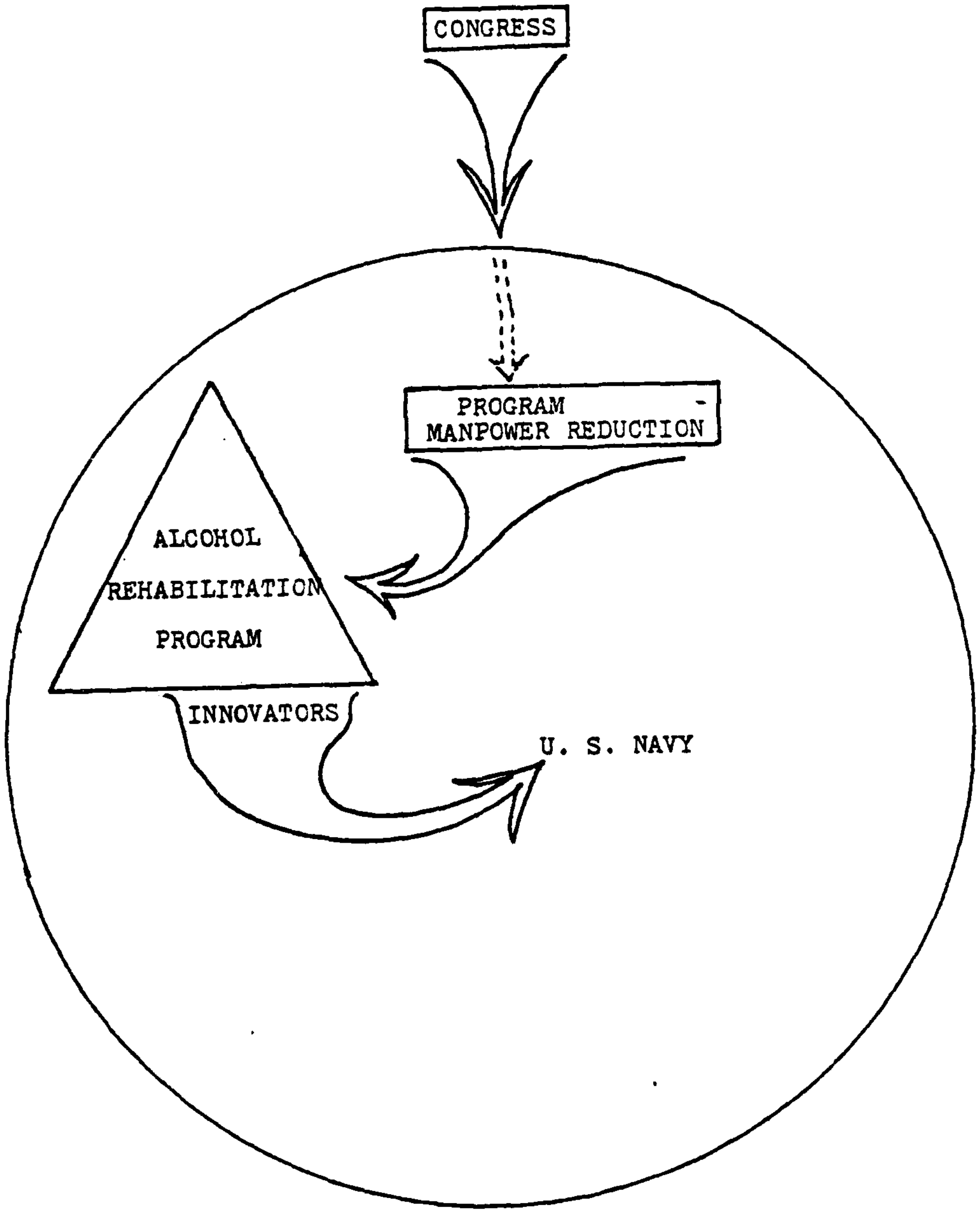

FIGURE 4

worldwide to provide assistance without the typical penalties of additional administrative burdens to those commands. It was a call to take the troublesome alcoholic from the command and return to them a far better worker in a few weeks, without cost or obligation. The Program was marketed well by these innovators.

In servicing the needs of the Navy, the Alcohol Program had served itself. As stated previously, the leadership of the Program were generally Alcoholics Anonymous Alumni. They had the power and opportunity to do more for alcoholism in the Armed Forces than anyone before them. The A.A. twelfth step (Appendix A) is a true calling for those recovering from a bout of alcoholism. It was probably never used as effectively as it had been in the Navy from 1971-1977. Virtually every major decision made on alcohol abuse covering 500,000 Naval members was "ghost written" by recovered alcoholics in NAPP. They changed policies of Navy enlisted, non-commissioned officer and officer clubs around the world. In addition, they were generating a self-renewal capacity for the Program through the 20,000 Navy and Marine personnel rehabilitated annually. They also used the Navy's sensitivity to alcohol abuse to gain support from major commands for treatment programs.

It was now under the Assistant Chief of Naval Personnel for Human Resource Management and left the project status.

It had been recognized by the Navy as a bona fide sub-unit in support of it's forces. With its new found security the Program leaders took advantage of the opportunity.

The name of the Program had changed to the Navy Alcohol Prevention Program (NAPP) in 1973. It was now able to take advantage of the prevention label. With the treatment centers structurally sound within the organization and being utilized to capacity, the leaders of the Alcohol Program thought it advantageous to reorient the Program to prevention and education. NASAP was virtually an undisputed success.

But the Navy still had a problem. The Alcohol Program and personnel were still highly aggressive and innovative. The Alcohol Program appeared to be quite successful, but the Navy had little control over some of its leaders. These leaders had little to lose personally by fighting or manipulating the system. They were not out to further their own careers, but perceived themselves as "saving lives." This was a strong motivation indeed. Also, the specialized skills necessary to operate the Alcohol Program were new to the Navy. The treatment was generally nonroutine. Every patient presented unique problems and the Program was heavily oriented toward the Social Sciences rather than the "Hard Sciences."

How the Navy coped with these problems is the subject of the next chapter.

VI. BUREAUCRATIZING (1977-1980)

"We trained hard...but every time we were beginning to form up into teams, we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing...and a wonderful method it can be for creating the illusion of progress while producing inefficiency and demoralization."

Petronius, A.D. 66

A. INTRODUCTION

As stated in the last chapter, the Program had been fully assimilated by the Navy by 1977. While this had the advantage of assured funding, manpower and recognition, it also created problems for the Alcohol Problem.

Acceptance by the Navy for this unusual service to it's members did not come without cost to the Program leaders. The immediate result in these later years was loss of program flexibility and a lower tolerance level by the Navy for the innovators' style of "creative" leadership.

It was true the need by the Navy had been recognized, but now it appeared inevitable that the parent organization was moving to resolve this need in its own style. Among the issues facing the Alcohol Problem from the Navy during this time period were:

1. A movement by the Navy to merge the Alcohol and Drug Program into one office, under one director.

2. Control of NADAP from a single point instead of the current diffusion of reporting requirements.

3. The merging of CAAC's and ARD's, since many were co-located.

4. Removal of NASAP from the control of the Commanding Officer, ARC, San Diego, to Chief of Naval Education and Training (CNET), located in Pensacola.

5. The drive to combine the ARC's (a line function) and ARU's (a BUMED function) to come under BUMED control exclusively. This would eliminate the line function from the inpatient treatment process.

Not all of these issues are resolved today. The resistance was high against changing the direction of the Alcohol Program by it's leaders. The ability of these personnel to hold back the pressure being applied by the Navy is in doubt.

This chapter will review these and other applicable issues.

B. THE CHANGING WIND

The changes foreseen in 1976 by the Alcohol personnel in their organizational makeup, were about to be implemented. Just prior to mid-1977, the Alcohol Abuse and Drug Abuse Programs were combined under one head. It was stated the merger was to form a single, integrated administrative division for the two programs. The program was called Navy Alcohol and Drug Abuse Program (NADAP) and was under the management control of the Assistant Chief of Naval Personnel for Human Resources Management (Pers-6).

The affiliation with the Drug Program occurred much to the consternation of many of the Alcohol Program personnel.

However, the leaders of NAPP saw no need for immediate alarm. They knew the first NADAP Director would be an Alcohol Program representative by virtue of seniority. With their man at the head, the merging of the two programs could then have meant a reallocation of personnel and dollars currently devoted to Drug Abuse Programs. The real result of this marriage is not clear due to conflicting data; however, the Alcohol Program lost little ground initially and continued to press for additional Alcohol Program funding. The Drug Abuse Program was not nearly as visible in the literature reviewed.

The Alcohol Program did make some gains, by the end of the year:

1. Two hundred doctors were trained at ARS Long Beach's Alcoholism Orientation Course.

2. Over 1,000 Navy Chaplains, both active duty and reserve, completed a 3-day workshop on alcoholism.

3. Thirty Alcoholism panel presentations were presented to Naval forces in the United States as well as the Western Pacific, by the Commanding Officer ARU Long Beach and the current Director of NADAP.

4. Eleven NASAP sites were manned and operating by October with a total of 13 expected shortly.

5. Fifty CAAC/ARD's were in operation. Some had combined services by the end of the year.

6. Eighteen ARU's were operating in Naval Hospitals.

7. Close to 20,000 had received rehabilitation or assistance for their alcohol problem this year.

8. The Program began development of a 5-year plan for Human Resource Management, of which NADAP was a part.

With the merging of the Alcohol Program and Drug Program came additional calls from the Chief of Naval Personnel for streamlining the NADAP system. Some of the problems addressed in the introduction of this chapter surfaced in late 1977. Specifically, the merger of the Alcohol and Drug Program had taken place, and the combining of ARD's and CAAC's appeared imminent.

By 1978, this marriage of ARD's and CAAC's had come to pass. The ARD name was dropped and all their services moved into the CAAC's with which they were co-located. The stated purpose was to provide stronger, more comprehensive facilities to the abuser of drugs/alcohol, and the newest phenomena, the polyuser. This was the Navy man or woman that was abusing both drugs and alcohol (a former Commanding Officer of an ARU prefers the title "chemical gourmet").

The CAAC's were formally centers dedicated to the drug abuser. They were under the control of local commanders. The advantage of this local control was the accessibility of the Program to the personnel assigned to the area. The disadvantage was that the effectiveness of the CAAC was directly dependent on the involvement of this local commander. He/she held the purse strings. The result was the extreme variance of effectiveness of the CAAC's. Some were truly outstanding, others were close to closing.

In addition, the CAAC's did not enjoy a good reputation throughout the Navy. Many were perceived by senior officers

as a "babysitting" service for the personnel who couldn't cope. The CAAC's did little to alleviate these feelings of distrust in their early development. For example, there were a few that had classroom walls painted in vivid colors and covered with posters of popular band members, etc. The grooming standards of some counselors attached were considerably less than that tolerated by more conservative Naval personnel.

The assignment personnel in Washington D.C. were adding to these problems. Formally CAAC's were designed to be headed by full lieutenants or warrant officers. Instead, very young and inexperienced officers, ensigns or fresh lieutenant junior grades were assigned (primarily females). They generally did not have the experience or power to fight for their Center's survival. This added to the fact that little coordination among the CAAC's was being done; the CAAC system was getting into trouble. Only a few CAAC's were perceived by their local commanders as serving the needs of their commands. This also remains an outstanding problem that must be resolved before the real effectiveness of this system can be felt.

There was another major occurrence to impact the Alcohol Program in 1978. There had been a Congressionally directed split of; one, policy and planning; and, two, implementation and operations, in the Navy's Personnel branch. The organizational responsibility was to be divided between the Deputy Chief of Naval Operations (manpower, personnel and training)

for policy and planning, and the Naval Military Personnel Command (NMPC) for implementation and operations. For the programs addressed in this study, it became Op-15 and NMPC-6, respectively.

The new NMPC-6 (old Pers-6) was still responsible for the NADAP facilities; e.g., ARC's through NMPC-63. However, the rest was quite confusing, especially in policy development. The question was, who was really creating a comprehensive policy statement? It was only a slight exaggeration for the Alcohol Program leaders to shrug their shoulders and declare "Who's in charge here?" This had not been resolved prior to the split other than in general terms. The Centers in the field had little insight on why the change happened in the first place, and ultimately what had really changed.

There are currently two NMPC-6 representatives in Op-15, but their mission is not clear, at least as far as the NADAP personnel in the field believe. Meetings are currently ongoing to resolve these problems at the time of this study.

It must be noted the Navy was forced into this transition, but they had also failed to smooth out the process. The split was to allow for more effective management of Naval programs. It may in fact turn out that way, but not without a considerable amount of additional homework on the process.

The final major action for 1978 was BUMED's assumption of total control of ARU's. They assimilated all ARU's into functional departments of Naval Hospitals and changed the

name to Alcohol Rehabilitation Services (ARS). The methodology for treatment of the abuser was unchanged.

As a review, by 1979 there were 3 ARC's, 24 ARS's, 66 CAAC's, and 18 NASAP sites in operation. These continued to treat thousands annually. NADAP would address the work of these centers and services in their information bulletin. They also broke out the results of the Drug Program which was not nearly as dramatic. The emphasis clearly remained on the Alcohol Program and virtually all subsequent Directors of NADAP were recovered alcoholics.

Milestone events for 1979 are few. The leadership was coping with their new responsibilities and loss of flexibility with the Op-15/NMPC-6 split. There were still not enough counselors to handle the long waiting lines for entry into treatment. It appears that limited space was available to treat additional patients, but the shortage of personnel made the task impossible. The manpower problem was being felt Navy-wide. Most all commands,including the support units,were giving up a "fair share" amount. The Program had slipped into a "station keeping" position. It was fully supported financially, and manpower was provided in accordance with shortages present throughout the Navy, but few innovations were now made or in fact tried. The budget for dedicated Alcohol Programs was level at 12 million dollars for 1978 and 1979. It was programmed to rise to only 13 million dollars by 1980.

Another peculiar phenomena was taking place at the treatment centers. The average age of the typical patient was younger. The patient of 1971-1975 was typically over 25 years old, but now the trend was reversing. It was obvious by 1979 that the under 25 group was the norm.

There was a great deal of concern over this issue for a number of reasons. First, a great many of the younger abusers were polyusers, so confusion reigned on which problem to deal with first, alcohol or drugs. Second, the concern was that with a shortage of personnel in most jobs throughout the Navy, the older technically proficient sailor who was an alcohol abuser, was now being tolerated by the commands. The feeling being that an alcoholic on the job is better than none at all. No replacements for the command was possible when a patient was admitted to a Center. Finally, the success rate of rehabilitation of the younger abuser was significantly below that of the older patient. These concerns also are unresolved to date. The basic difficulty was how to measure these enigmas.

Truly, the Program desired to help those in need but it also had to pay its own way. One can appreciate the dilemma of the Program leaders. It was faced with a younger patient that was harder to treat. In addition, the Program felt, but did not know, that the real, older, alcoholics were being hidden by commanding officers because of personnel shortages.

This meant their primary goal of "saving lives" was perceived to be stagnating. Finally, in justifying the Alcohol Abuse Program, it is difficult to display sliding success rates without considerable explanation.

By comparison, 1980 was even a more bothersome year from the perspective of the Program leaders. Studies both by internal sub-units and contracted organizations external to the Navy were taken to review cost effectiveness and justifications for the Alcohol Programs.

The most significant of these studies was done by Burt Associates, Incorporated, titled "Worldwide Survey of Non-medical Drug Use Among Military Personnel, 1980." It was a sweeping study touching on all aspects of drug and alcohol abuse. Conclusions were not drawn by the contracted consultants, but the charts clearly illustrated the story. The Navy was an abuse leader in many of the categories under alcohol and drug problem areas [19]. This was released to major commands in late December 1980. The effects are not obvious at this time but it is speculated the Alcohol and Drug Program will get additional attention due to this perpetually festering problem. At the very least, it certainly will result in the typical "knee jerk" reaction of additional studies in an attempt to localize the problem.

Other major problems addressed in 1980 by major studies, were the proposed integration of NASAP into CNET control and the combining of the ARC's into ARS's under the control of BUMED.

The intriguing part about these problems was the addressal of the same proposals of their unification virtually every year since the birth of the ARC's in 1971 and NASAP in 1974. This was not fresh news to either one of these programs. Both suggestions were categorically rejected by early Alcohol Program leaders who convinced their boss that these moves were most impractical. This was able to be done in those early development years without much required justification. Today the powerbase is not the same, and neither are the personnel.

The criticism leveled at NASAP was the control of the Program being held in ARC San Diego. The flow was not logical to those reviewing the organizational structure. The Navy had been touting this program as preventive education. Why then, was it operated from an ARC, a treatment center; why wasn't it controlled by Chief of Naval Education and Training in Pensacola?

One obvious reason was the fact that the Commanding Officer of ARC San Diego was a founding father of NASAP in 1974. The Program was carried with him when assuming duties at the San Diego ARC. A second reason for the placement at an ARC, was to utilize the expertise of ARC personnel in continuing development of NASAP. Treatment and rehabilitation are two completely different worlds in the civilian community, with no interchange of information. It was felt the move to an ARC would provide more necessary coordination

between the Programs. This interchange was paramount if NASAP's success were to continue. Third, a high number of NASAP referrals are screened for additional treatment to ARC's or ARS's. Estimates are as high as 15 to 20 percent, stating that, "CNET would not have that expertise or capability for control if it was held in Pensacola."

The move to CNET has been dismissed by program leaders as impractical and they felt strongly that it should remain in the rehabilitation network. CNET apparently does not desire, or is not ready, to crusade for acquiring NASAP. No documentation was found concerning CNET's opinion.

The move to integrate the ARC's and ARS's was even more perplexing. This had been addressed since Captain Zuska's Center became officially operational in 1971. It has been recommended in not less than 3 major studies, yet it was rejected each time.

The argument to unite the services and centers appears to be quite logical. It was felt that consolidation of assets would improve utilization, increase efficiency and assist coordination. The major argument, however, was that if alcoholism was a disease as the Program personnel had professed since the beginning, why wouldn't it be better in a hospital environment?

The emotion tied to this issue can not be underestimated. The fight to keep the Navy Alcohol Services and Centers split, was apparently a threat to the entire issue of

rehabilitation in the Navy. The fascinating aspect of this issue is that BUMED does not desire to assume full responsibility for alcohol rehabilitation. They do not have the manpower or facilities to take on the whole task.

The arguments presented to keep the ARC's and ARS's separated were many, but the most important issue as far as the Alcohol Program leaders were concerned, was management. As addressed in earlier chapters, both the operational side and medical side had their hand into treatment. Both NMPC and BUMED felt it should remain this way for a number of reasons. The primary thought was that if BUMED took control over the entire process the "Line," or operational Navy, would then feel little identification with the problem and would lose it's sensitivity to alcohol abuse. It was felt support for identification and referral for treatment of the alcoholic would collapse. If, on the other hand, it were given entirely to the "Line," the Medical Department would also feel little responsibility to support the program.

BUMED felt that even as an identified disease, alcohol abuse and alcoholism could be normally treated effectively outside the hospital environment. As addressed in Chapter IV, the ARC's and ARS's used a multidisciplinary blend of medical treatment, group therapy, education, spiritual reinforcement and individual counseling. The medical treatment was primarily oriented toward detoxification, the withdrawal of the addict from alcohol. This had to be handled at the

hospital level due to the critical nature of the detoxification procedure. But other minor problems could be handled quite adequately at ARC's. One of the real reasons for required medical involvement was referrals for treatment. Numerous alcoholics had been identified through emergency room treatment of automobile accident cases, spouse or child abuse, chronic illness, etc. It was necessary to gain the support of the Medical Department to ensure continued referrals. Often the stigma attached to alcoholism was perceived by the doctors as being worse than the injury requiring medical care. Without continued involvement by the medical staff, it was possible for many alcohol abusers to continue their problem drinking due to a "sympathetic" doctor.

NADAP had other reasons for dual involvement. They quite frankly felt that the medical doctors were generally very poor managers and that the program would not organizationally survive if run by the medical department. The NADAP personnel also felt that BUMED was never very supportive of the Program in general and came into the picture because of the dollars and CNO insistence. Finally, NADAP felt that the Alcohol Program reached maturation because of the understanding of recovered alcoholics who made up a large part of the Program organization, that their motivation and zeal carried the idea of a viable rehabilitation program into reality.

The arguments for and against the integration of ARC's and ARS's are many and will have to be resolved soon. There

is continuing pressure to smooth out the rough, fragmented organization of the treatment programs. It is speculated that this pressure will build until the CNO makes a declaration on the makeup of the Alcohol Program for the future. The worry with the NMPC-63 staff is the loss of influence. It has lost the ability to guide much of it's own destiny as had been possible in the past. There are new programs including Family Advocacy, Weight Control, and Physical Fitness that are requiring additional attention. These are the responsibility of NMPC-63 under NMPC-6 and they will have to utilize scarce NADAP resources to answer the call for action.

The future appears to be a bit confused.

C. CONCLUSIONS

This was a period of bureaucratization for the Alcohol Program. While it had been assimilated into the Navy structure between 1974 to 1977, it had not yet conformed to the standard operating procedures of the parent organization.

The characteristics of a bureaucracy, as defined by William Haga [20], had been fulfilled in the last three years:

1. The Program was specialized for efficiency. Virtually all counselors were trained at schools co-located with the ARC's. It was geared to understanding the alcoholic and directed to the best way to treat him/her, as the Alcohol Program perceived the problem.

2. There existed a hierarchy for control. In fact, a new line of responsibilities, while somewhat disjointed, was recently established for tight regulation. It was getting more and more difficult for the Alcohol Program to penetrate the layers of command above them to initiate new programs or expand established ones.
3. By establishing new responsibilities and management policy, it blocked the formally aggressive directors from effectively influencing the hierarchy. In other words, the job was more important than the personality of the individual in the position.
4. The leaders now had limited power. They could not circumvent the chain of command but had to work within the newly limited scope of the job.
5. Careers were possible within NADAP. The enlisted Navy Alcohol Counselors had codes to identify their specialty. It was declared that officers could serve in the Program without stigma, although there is little evidence to support this claim by the Navy. Promotions prove the opposite. However, with the expanded responsibilities of NMPC-63, it was possible to work in other related areas and return to the Alcohol Abuse Program.
6. It was a full time responsibility, without a doubt. The leaders would have preferred even more personnel and time devoted to the Alcohol Program.

7. The authority of the Director was based on the position, not the charisma of the person in the job.

Obviously, this did not happen overnight. It is speculated the Navy had been attempting to bureaucratize this Program since 1976 when virtually all the treatment and education facilities had been established. The Navy felt it time to get control.

The treatment worked. The Alcohol Program was successfully returning alcoholic service members back to their commands as productive workers. But the Navy perceived that their needs had been fulfilled, a successful program was in operation, therefore innovation was no longer necessary. The Program continued to be fed money, but certainly no radical departures were tolerated as had been in the past. The personnel were still by and large recovered alcoholics but in a "station keeping" status. New fights for additional centers, services, or counseling centers, were lost before they really got off the ground.

So the Navy had accepted the new Program. The original shock waves of the early 70's had settled down. It was an established support system in competition for dollars and manpower on an equal status with other established support programs.

This is not to say the Alcohol Program is ineffective. Despite the gearing down, the treatment and education facilities are still working at capacity on roughly the same success

rate for the last 4 years. It remains cost effective, and is recognized by the Navy as more than paying it's own way.

VII. CONCLUSIONS

A. INITIAL CONCLUSIONS

As stated in Chapter II, early support (1965-1970) by both the public and private sector for Alcohol Rehabilitation Programs was virtually non-existert. For the Navy, it was two individuals who formulated a "bootlegged" program. Although the Alcohol Rehabilitation Program took shape at Long Beach, neither of these two designers of the treatment program had the power or influence to convince the Navy that the program had a future. Indeed, they had trouble convincing their own Command, the Bureau of Medicine and Surgery (BUMED) that this program was a viable solution to alcoholism.

The then current personnel needs of the Navy as a whole were convincingly met without having to allow the development of an additional sub-unit. This was largely due to the existence of conscription. Mission accomplishment was apparently not hampered by the claimed high costs associated with toleration of alcoholics in the working environment. Conscription was keeping most of the manpower coffers full, although re-enlistment rates were falling sharply.

The situation for the Navy until 1970 was to tolerate this idiosyncratic experiment of alcohol rehabilitation at Long Beach. It is speculated that the perception was that the cost was minimal in both facilities and manpower, and

therefore allowed to happen. In fact, one of the originators operating the unit worked as a non-reimbursed volunteer for four years at the Long Beach facility. The two individuals did continue to perfect the treatment process by trial and error, utilizing the Alcoholics Anonymous (AA) model as the basis for development. It was not clear what the intentions were of this early development. It was assumed that "saving lives" was the bottom line, as it was in AA. Obviously, no long term strategy could be developed at this time, for survival of this small experiment was a day-to-day fight. There were no forces strong enough to allow any significant growth of this sub-unit. The Navy had no reason to listen.

As 1970 approached, the three major forces addressed in Chapter III were formulating. All three of these forces had the potential to be major disruptions to the status quo of the Naval organization. The Vietnam War was having major impacts already. The selection of a liberal Chief of Naval Operations would surely result in some changes, the question was how much. And the passage of Public Laws 91-616 and 92-129, while not earth shattering, certainly added fuel to the fire for recognition of alcohol abuse as a problem that must be dealt with by the Navy. Undoubtedly, there were other justified programs vying for attention at this time. The reason that this was one of the programs that got funding and personnel to establish itself, was due to the innovative personnel who took charge of the development.

These innovators had no major issues to quickly align with as did other programs. For example, race relations had the power of civil disruptions and finally riots aboard Navy ships; the drug program had highly visible documentation of massive addiction of troops in Vietnam. There was no major publicity that the Alcohol Program could use as leverage, just an accumulation of many smaller issues.

It is well beyond the scope of this thesis to review the reasons for the major social changes taking place in our society during this time. But it is important to note that the appointed leaders of the Alcohol Program used this environment of social change to make major advances in the development of alcohol rehabilitation treatment. Given the go ahead by the Chief of Naval Operations, they set out to construct a package for recovery of the alcoholic in the Navy. The reason that the program was even given a chance was the intersecting of these major forces addressed in Chapter III.

The recovered alcoholic leaders of this program were truly zealots for alcohol rehabilitation. It was something few would understand who have not been laying drunk "at the bottom of the cliff." Numerous books have been written on the psychological makeup of the typical alcoholic and effective treatment. Suffice it to say that there appears to be no "typical anything" in alcohol rehabilitation. It is unique in personalities and treatment. But as previously stated,

most of the personnel in the beginning of the development of the Alcohol Program reached their current recovery level through Alcoholics Anonymous. This was a group of alcoholics devoted to helping alcoholics. Their philosophy included the belief that they were never permanently "cured." It was life away from the bottle on a day-to-day basis. There were no guarantees that reversion to past habits of excessive alcohol consumption was not possible. While appearing short-sighted, it apparently was the most effective method of treatment found by these personnel.

There were advantages to this Program developed by AA personnel. They had true understanding of the patients they were attempting to place in rehabilitation. With this insight, it would be possible to establish the credibility with the parent organization of what a rehabilitation program can and can not do for the patient.

Indeed, to fashion an Alcohol Rehabilitation Program that would be effective, these first leaders and workers were needed. It would not have been possible to make any rapid advancements without their total devotion to the creation of the Program. A glance at the failures of the Army and Air Force to get their program running without the recovered alcoholics' direction is positive testimony to the proper avenue that the Navy took.

While much of middle management and some upper management were not the least bit anxious about alcohol abuse,

the CNO was deeply concerned. This markedly changed the supporting structure for the Program, if not the attitude toward it. Readjusting this negative attitude toward alcohol rehabilitation was to be an uphill battle that still is not completely resolved. It certainly was not ignored by the Program leaders. Captain Jim Baxter, the first Alcohol Program Director, spent literally weeks on the road talking to anyone who would listen about what the Alcohol Program was to accomplish. As stated by an early alcohol program leader,

> "We were not a temperance organization; we were not changing to that...we were changing the view of what an alcoholic and alcoholism was."

One of the conclusions of this study is that these recovered alcoholics were not performing strictly for the Navy or to serve the Navy's goal, rather they were oriented to Alcoholics Anonymous twelfth step (Appendix A). In servicing their own needs through the Navy, they were highly motivated and would go to extraordinary lengths to ensure proper programs were initiated. This "crusader" atmosphere resulted in these innovative personnel establishing far reaching treatment, but directed exclusively to alcohol abuse. Because there was little identification by the recovered alcoholic with illicit drug abuse, affiliation with this sister program was avoided. The only apparent connection was through utilization of the Drug Abuse Program assets.

The Alcohol Program leaders did easily identify, and were deeply concerned, with the "closet alcoholic." A "closet alcoholic" would not normally seek help, but might accept it if confronted with their drinking problem. It was important for the Program to identify and bring out these hidden and often protected abusers. Once identified, treatment could be ordered, for acceptance of treatment by the alcoholic was not one of the criteria for referral. It came to pass that an identified alcoholic could be sent for rehabilitation against his/her will. This was to overcome the often vehement denial by the alcoholic of recognition of their obvious abuse problem. This referral policy was certainly quite an achievement for the Program leaders.

These innovative early Alcohol Program leaders could have confronted much resistance while selling their Program. They were a minority, but venturesome and eager to try new ideas. This, coupled with the burning desire to help others that had their same problem, would have made it difficult if not impossible to dampen their enthusiasm when given the resources to make it all possible. The innovations presented by these leaders certainly could have been rejected by the system if the system felt the change unnecessary or unwarranted. The Navy collectively turned down very little that the innovators presented in the turbulent years of development from 1971 to 1974. The reason for this was the proper handling of the introduction of this new rehabilitation program by it's

leaders. The Alcohol Program was in a project status which gave them the blessings of the CNO to cross lines of authority throughout the Navy to resolve any differences. Project status also guaranteed "fenced" funds and billets. Captain Baxter and his office were well prepared with development plans, success statistics, and unbounded enthusiasm. The Program was sold to other Commanders as being cost effective for the Navy as a whole, and a vehicle for the Commanders to derive assistance for the little understood problem of alcoholism. The personnel shortage was not severe yet, the Commanders could generally afford to give up a member of their command for the possibility of gaining a better performer in 6 weeks. The commands had to do little for this benefit. It was cost free to them, and required no additional administrative burden. Truly one of the few no-cost, no-obligation, opportunities for the Commanders left in the Navy.

Although beneath the umbrella of the Human Goals Program, the Alcohol Program did not visibly align itself with it. They felt the Human Goals Program did not enjoy a positive reputation among the Line Commanders. So while this organizational structure was not overtly denied by anyone in the Alcohol Program, they did not offer a diagram of their chain of command to briefed commands if it could have been avoided.

The Alcohol Program also went to great lengths to ensure the traditional values of the Navy were not dislodged. All ARC's were run as military organizations with personnel

inspections and most of the other "amenities" of a typical military command. There were problems in the beginning with liberalization while undergoing treatment, but it was discovered that maintaining military discipline at the Centers did a great deal to maintain the credibility of the Program.

The resources to carry this Program through came from a variety of sources. The leaders were just as creative in this endeavor. They had a non-alcoholic supporter with Rear Admiral Rauch. Captain Baxter and friends would present convincing arguments covering expansion of alcohol rehabilitation and Rauch had the capability to produce the funds. This teamwork resulted in a great expansion of the Program in a relatively short time. It was during these years that the Program was formalized, but total integration by the Navy was not to come about for a few more years.

By 1975, the Alcohol Program had made its point; it was a cost effective vehicle for the Navy to salvage its alcoholics. Virtually all the rehabilitation treatment centers and units were in place and NASAP was proving its worth. The Program leaders were still creating most instructions and notices concerning alcohol abuse policy and procedures. They had been completely divorced from the Drug Program and continued to press for prevention of alcohol abuse.

In the hustle and bustle of the struggle for recognition, the Program became what appeared to be a structural nightmare. Specifically, there were numerous commands involved in the

process of treatment of the alcoholic. However, the "many hands in the pie" game was strongly supported by the designers of the Alcohol Program. For example, it was felt that the BUPERS/BUMED split was very important to the survival of the Program as an effective treatment plan. This was primarily due to the referral problem as addressed in an earlier chapter, where identification of alcohol abusers could come through recognition of certain injuries in the hospital emergency rooms.

In addition, other commands had an input to the identification, referral and treatment of abusers. As the Program stood in 1976, and still does today, the ARC's were under BUPERS (now called NMPC), the ARS's were under BUMED, and the CAAC's were under Commander-in-Chiefs of the respective fleets (CINC's). In addition, some NASAP's were controlled through NMPC and others locally. Certainly this presented problems, like career planning, effective cross talk among facilities, and perpetual tension between all the commands involved. But the Program felt this total involvement was absolutely necessary for recognition, cooperation, and referrals. As long as they all had to accept the responsibility for identifying and helping the abuser, the abuser would in fact receive assistance. So despite the fractured approach, it seemed to have worked. It resulted in broaching alcoholism at all levels of these commands and very broad coverage in the "Fleet" for identification of alcohol abuse.

As stated in the Conclusions in Chapter V, the aggressive leaders of the Program felt they had little to lose by taking such an unorthodox approach. The potential benefits far outweighed the possible negative impact on their career if it failed. Personnel careers mattered little, their assumption being that selection for a higher rank was encumbered with the recognition that they were once alcoholics. Evidence seems to support that perception. This author could not find, in all these interviews, an example of how one leader in alcohol rehabilitation was rewarded by promotion to a higher grade in all of the 1970's. Instead, they created what one might term a second career within the Navy, by using the organization to further their belief that alcoholics can be saved from their disease.

On the other hand, the Navy was allowing Alcohol Program growth based on decisions made by this sub-unit. The Alcohol Program, of course, created its own criteria on what was adequate growth. Whether this was realized by the Navy at this time is unknown, but by 1978, senior Navy officers tried to gain control again. The Alcohol and Drug program was forced to merge, as were the CAAC's and ARD's. This streamlining reduced the overall influence of the Alcohol Program. This effect was not immediate. At first the leaders used the combined Program as a basis for reallocation of more effort to the Alcohol Program. But pressures for recognition of the drug problem and eventual addition of other programs

like Weight Control and Physical Fitness to the shop where they worked, forced a de-emphasis. The Directors were still recovered alcoholics, but tolerance by the Navy for their innovative character had worn thin.

The Program could not hold back the surging tide of bureaucratization. The price the Alcohol Program had to pay for recognition by the Navy was full assimilation into the Navy and operation in accordance with the Navy's standard procedures.

B. FINAL COMMENTS

The Navy perceived this Program as a rider to other social action programs under Admiral Zumwalt's Human Goals plans. But as the Alcohol Program developed, it proved it's cost effectiveness in treatment of active duty personnel. In a different time, even this may not have been enough to ensure survival; however, with the predicted reduction in manpower in the winds, this was another story. The Alcohol Rehabilitation Programs were designed to return well trained active duty members to productive work. Given the Alcohol Program generated statistics, it could prove that it could provide more productive manpower at a reduced cost. The Alcohol Program leaders approached the whole issue with what the treatment could do for the Navy, and the Navy proved to be a willing customer.

It is strongly felt this Program growth, as illustrated here, would not have happened as rapidly without the recovered

alcoholics' participation. The system had rarely encountered such dedication to development of a program. Constant stimulus was offered externally by AA to these recovered alcoholics, throughout this Program development. In addition, these mavericks were permitted to freely travel across command lines of authority much like a developing child was tolerated by a parent. However, before long it was expected to fall in line with current values and procedures. The tolerance for digression from expected normal behavior in the system was decidedly lower after maturation of the project. It was allowed to develop and it developed into one of the most favorably recognized rehabilitation programs in the nation. But the Navy has now said, "enough is enough, it is time to get control."

Just as these innovators were necessary for the growth of the Program, they could quite possibly do it irreparable harm if they addressed today's problems as they did 10 years ago. Gone is the protection of top level support, the tolerance for the behavior of the early Program leaders, the freely accessible budget, the power of single layer management, and external forces to keep the Program visible. Without these supports, innovation can not flourish.

The advantages of innovation, flexibility, creativity and high motivation, are now perceived by the Navy as far too heavy a price to pay for the potential benefits. For the Navy to allow innovation, it is permitting a certain loss

of control. And as expected, the Navy desired tight control of all its branches, including NADAP.

As Charles Perrow points out, it would take enormous resources for the Navy to treat each case, or sub-unit as unique [21]. The tendency of a large organization like the Navy, was to pigeonhole the process. In this case, allowing the sub-unit to function, but in accordance with the parent organization's needs and procedures. This included formalization of the sub-unit.

However, the early leaders did tailor their Program to a certain extent to the Navy's goals, as an insurance policy for successful institutionalization of alcohol rehabilitation into the organization.

It should not be forgotten that this was done by the Program leaders to service their own perceived needs. But in the end it became a bureaucratized structure like the one for which they were working. As a result of the full bureaucratization, the current leaders are not faced with many of the choices that their predecessors had. Any desired deviation by the Alcohol Program from the norm, from that already institutionalized, will take a massive effort.

This is not to say the Program isn't doing the work for which it was established. The early developers did a magnificent job of structuring Centers and Services for rehabilitation, and initiation of NASAP, the prevention program. As addressed earlier, there are problems to be resolved; however, it is

this author's conviction that just as the Alcohol Program was started to "save lives," it is doing so effectively today.

APPENDIX A

ALCOHOLICS ANONYMOUS'

TWELVE STEPS TO SOBRIETY

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We're entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

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12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

APPENDIX B

THE GOALS

WHAT IS PREVENTION?

Following an extensive nationwide examination of existing programs beginning with the federally-funded ASAP efforts, NASAP developed and accepted several basic hypotheses which, when validated, became tenets of the approach to the problem. Prevention is one of those tenets.

The purpose of prevention is to increase the individual's understanding of personally and professionally distinctive alcohol-related behavior. The NASAP program is aimed at reducing the number of persons whose potentially existing alcohol-related behavior adversely affects the way they carry out everyday living.

Prevention activities take place at three levels: primary, secondary and tertiary.

1. Primary prevention includes all activities that reduce the number of new cases with initial alcohol-related disabilities. It is based on an individual's formation of values, attitudes and beliefs and occurs principally in the formal education of K-12 or in the home — generally areas out of direct control of the Navy.
2. Secondary prevention efforts are directed to people who have non-addictive drinking-related behaviors such as often result from inappropriate use or occasional overuse of alcohol. This requires facilitating the change of existing values and attitudes of the individual — a NASAP process which can occur at any time.
3. Teritiary prevention refers to activities concerned with people who have severe alcohol-related behaviors. These persons are diagnosed as alcoholics. Therefore, screening and evaluation at the outset become key elements of the program. Individuals who show a need for more extensive care for referred for clinical diagnosis and treatment.

HOW IS SECONDARY PREVENTION ACCOMPLISHED?

NASAP, as the Navy's secondary prevention effort, is designed to identify and reduce the problems caused by alcohol misuse and/or alcoholism. NASAP's efforts focus on addressing problems at the earliest possible stage, when they are first identified through civilian law violations, work-related accidents, military offenses, and hospital emergency room or sick call records.

NASAP, however, as an educational program that deals with basic attitudes which affect the whole person is, in its application, in no way restricted to those experiencing alcohol-related difficulties. Its use has been of equal value in the training and development of human behavior in supervisors, accession point candidates, medical personnel and others. Attitudes regarding alcohol and its use on a personal basis most often reflect the posture of others with whom an individual might have contact such as a supervisor, medical care practitioner, family member, friend or simply peer. If the attitudes of such persons are based on the many myths or misconceptions prevalent in society, they will be ill-equipped to help those who come within their sphere of influence.

IS THE EDUCATIONAL DESIGN UNIQUE?

The bilateral design of NASAP's education course is tailored to utilize the dynamics of both individual and group development (Figure 3). The curriculum carefully melds alcohol awareness with individual choice and change. The change model incorporated encourages the development of positiveness, motivation, and reinforcement for change within the individual. This change comes through emphasis on greater understanding of human behavior and testing of individual values and attitudes.

A FRAMEWORK FOR COURSE DESIGN*

NAVY ALCOHOL SAFETY ACTION PROGRAM

	LEVEL 1 Knowledge & Information	LEVEL 2 Human Development (Individual & Group)
SESSION I	Program Orientation	*Climate Setting*
SESSION II	Federal, State & Local Roles	Credibility
SESSION III	Human Body	Physical Ownership
SESSION IV	Driving	Confidence, Trust & Cohesion
SESSION V	Psychological	Personal Ownership
SESSION VI	Symptoms & Phases	Initial Commitment for Change
SESSION VII	Attitudes & Actions	Personal Change Alternatives
SESSION VIII	Attitudes & Leadership	Effecting Change in Others
SESSION IX	Helping Network	Support Systems for Change
SESSION X	The Family	Personal Support
SESSION XI	Supervisor's Role	Organizational Support
SESSION XII	The Beginning	Success — A Winner

*This Bilateral Design is tailored to utilize the dynamics of two domains — knowledge and behavior.

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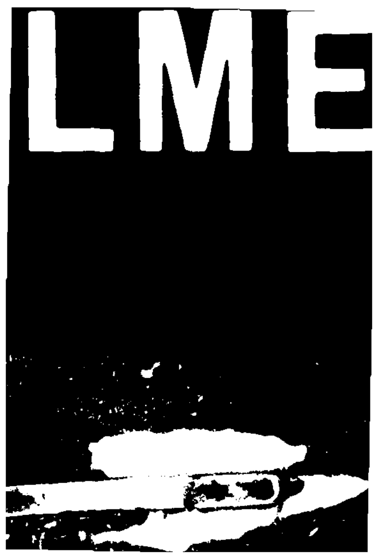
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